

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Approved by Coroner.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13013					13007						
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4600 Harlan Road--Aspen Hill</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>4600 Harlan Road-Aspen Hill</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Olivia</b> First <b>E</b> Middle <b>Pack</b> Last			4. DATE OF DEATH <b>9/6/66</b> Month <b>9</b> Day <b>6</b> Year <b>1966</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>July 18, 1890</b>			9. AGE (in years last birthday) <b>76</b>			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Frank E. Cummings</b>					14. MOTHER'S MAIDEN NAME <b>Emma</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>263-96-7306</b>			17. INFORMANT <b>Jean C. Pack 6000 Crawford Drive</b> Address <b>Rockville, Md. Son</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> <b>Coronary occlusion</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Short time</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 17, 1966</b> to <b>Sept 6, 1966</b> , that (I) (we) last saw the deceased alive on <b>Aug 17, 1966</b> , and that death occurred at <b>3:45 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>John N. Andrews</b> M.D.					22b. DATE SIGNED <b>9-6-66</b> <b>Maryland</b>		22c. PHYSICIAN'S NAME (Type) <b>John N. Andrews</b>				
22d. ADDRESS <b>9601 Colesville Road, Silver Spring</b>											
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>			23b. DATE THEREOF <b>9/8/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City, town or county) (State) <b>Silver Spring, Montg. Md.</b>				
24. FUNERAL DIRECTOR <b>Tyson Wheeler</b> <b>1331 Rockville Pike</b> <b>Rockville, Maryland</b>					25a. REC'D BY REGISTRAR <b>SEP 7 1966</b> <b>Charles Judge</b>						
25b. REGISTRAR'S SIGNATURE											

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13014

CERTIFICATE OF DEATH

13008

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY <u>Washington D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
c. LENGTH OF STAY IN 1b <u>2 mo. 1 day</u>		d. STREET ADDRESS <u>2526 14<sup>th</sup> St. Apt 66</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sen. &amp; Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Stewart Parnell</u>		4. DATE OF DEATH Month Day Year <u>Sept. 12 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-96</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>geologist (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Wm Parnell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bennett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no.</u>		16. SOCIAL SECURITY NO. <u>578-50-6065</u>	
17. INFORMANT <u>med. Records - W.S.H.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RESPIRATORY DISTRESS</u> DUE TO (c) <u>CA OF THE LUNG</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>METASTASES PROBABLE, URINARY TRACT INJURY</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-11</u> , 19 <u>66</u> , to <u>9-12</u> , 19 <u>66</u> , that (I) (we) lost sow the deceased alive on <u>9-12</u> 19 <u>66</u> , and that death occurred at <u>1044AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John L. Ford</u>		22b. DATE SIGNED <u>9/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN L. FORD MD</u>		22d. ADDRESS <u>831 UNIV. BLVD. N. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/15/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>The S.H. Klein Co. Wash, DC</u>		25. REGISTRAR'S SIGNATURE <u>SEP 14 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or any other event, within 72 hours after death.

80081

WATER 13. STATION 100

81081

WATER 13. STATION 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

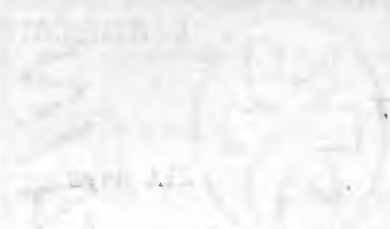
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>13015</p> <p><b>MARYLAND STATE DEPARTMENT OF HEALTH</b> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b> <b>CERTIFICATE OF DEATH</b></p> </div> <div> <p>13009</p> </div> </div>																																			
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>214 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>11 Clement Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
<b>3. NAME OF DECEASED</b> (Type or print) First <b>William</b> Middle <b>John</b> Last <b>Patton</b>			<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>10</b> Year <b>1966</b>			<b>5. SEX</b> <b>Male</b>			<b>6. COLOR OR RACE</b> <b>White</b>			<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>12 July 1936</b>			<b>9. AGE</b> (In years last birthday) <b>30 yrs.</b> IF UNDER 1 YEAR Months Days Hours Min.																	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Education</b>						<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland-Lonaconing</b>						<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>																	
<b>13. FATHER'S NAME</b> <b>William B. Patton</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Geraldine White</b>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>1954-1958</b>						<b>16. SOCIAL SECURITY NO.</b> <b>577-52-6642</b>						<b>17. INFORMANT</b> <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda, Maryland</b>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Pulmonary Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myelogenous Leukemia- in Blast crisis</b> (c) <b>Hepatic insufficiency of unknown etiology</b>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>32 hours</b> <b>7 Months</b>																							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Hepatic insufficiency of unknown etiology</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)						<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>						<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)						<b>20f. (City or town) (County) (State)</b>					
<b>21. I certify that</b> <input checked="" type="checkbox"/> <b>(this hospital) attended the deceased from</b> <b>8 February, 1966</b> , <b>to</b> <b>10 Sept., 1966</b> , <b>that</b> <input checked="" type="checkbox"/> <b>(we) last saw the deceased alive on</b> <b>10 Sept., 1966</b> , <b>and that death occurred at</b> <b>8:15M</b> , <b>from the causes and on the date stated above.</b>																																			
<b>22a. SIGNATURE</b> <i>Jerry L. Spivak</i>												<b>22b. DATE SIGNED</b> <b>11 September 1966</b>																							
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Jerry L. Spivak, MD.</b>												<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>																							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>						<b>23b. DATE THEREOF</b> <b>Sept. 15, 1966</b>						<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Restlawn Memorial Park</b>						<b>23d. LOCATION (City, town or county) (State)</b> <b>Near Cumberland, Md. Allegany</b>																	
<b>24. FUNERAL DIRECTOR</b> <b>James F. Scarpelli, Cumberland, Md.</b>												<b>25a. REC'D BY REGISTRAR</b> <b>SEP 14 1966</b>						<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>																	

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13000



The Clinical Center, National Institutes of Health  
 Building 10, Room 3N202  
 Bethesda, Maryland 20892  
 Telephone: (301) 496-6100  
 FAX: (301) 496-6101

For information on the availability of the  
 Human Genome Project, contact the  
 Human Genome Project Information Center  
 P.O. Box 168, Bethesda, Maryland 20892  
 Telephone: (301) 496-6100  
 FAX: (301) 496-6101

The Human Genome Project is a  
 major international effort to  
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 human genome. The project is  
 coordinated by the International  
 Human Genome Mapping Consortium  
 (HGP) and the Human Genome  
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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
Item #9 1111-#0501 9/25/66													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47-3</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Westwood Retirement Home</u>						d. STREET ADDRESS <u>2725 29th St N.W.</u>							
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>G</u> Last <u>PAYNE</u>						4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1966</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-26-88</u>		9. AGE (In years last birthday) <u>78</u> / <u>7</u> / <u>9</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES REPRESENTATIVE</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>FAIRFAX County VA</u>				
13. FATHER'S NAME <u>FRANK L. PAYNE</u>						12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO.			17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>16 June</u> , 1966, to <u>18 Sept</u> , 1966, that (I) (we) last saw the deceased alive on <u>18 Sept</u> , 1966, and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Joseph J. Wallace</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>18 Sept 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH J. WALLACE</u>						22d. ADDRESS <u>1830 K St N.W. Washington</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>9-19-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>			23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>					
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>						ADDRESS <u>200 4th St WASH. D.C.</u>			25a. REC'D BY REGISTRAR <u>SEP 21 1966</u>				
									25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13017

CERTIFICATE OF DEATH

13011

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>13202 Okinawa Avenue</b>		d. STREET ADDRESS <b>13202 Okinawa Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Middle <b>C.</b> Last <b>PEARSON</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>30</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1911</b>
9. AGE (In years last birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>23</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arthur Posey</b>		14. MOTHER'S MAIDEN NAME <b>Laura Ennis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-20-1858</b>	
17. INFORMANT <b>Clifford C. Pearson-Husband-Same Item #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>coronary atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/1</b> , 19 <b>66</b> , to <b>9/29</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>9/29</b> , 19 <b>66</b> and that death occurred at <b>6:30</b> A.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Donald L. Bucy</b>		22b. DATE SIGNED <b>9-30-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DONALD L. BUCY</b>		22d. ADDRESS <b>809 Viers Mill Rd. Rockville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/3/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville Maryland</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 4 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

13012

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Green</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sylvan Manor Health Care Center</u> <u>2700 Barber St. S.S. and</u>		d. STREET ADDRESS <u>726 Richmond Ave.</u>	
4. NAME OF DECEASED (Type or print) <u>Pet John</u> First Middle Last <u>PETERSEN</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/11/1880</u>
9. AGE (in years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DENMARK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Not Available</u>		14. MOTHER'S MAIDEN NAME <u>Not Available</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-8961</u>	
17. INFORMANT <u>Carl A. Petersen (same as #2)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4500</u> DUE TO <u>generalized A.S., ASHD.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Hip fracture approx. 3 mo before death.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.) <u>fell at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10 - 5-1-66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>S.S. Mount Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6-1-1966</u> , to <u>9-18-66</u> , that (I) (we) last saw the deceased alive on <u>9-1-1966</u> and that death occurred at <u>8:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>L. P. Sengstack M.D.</u>		22b. DATE SIGNED <u>9-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. P. Sengstack M.D.</u>		22d. ADDRESS <u>9241, Columbia Blvd. Silver Sp Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 21, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Robert Walters</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. ADDRESS <u>254 Carroll St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>SEP 22 1966</u>			

cleared with medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>6 days</u>		d. STREET ADDRESS <u>6426 Knollbrook Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HUGH</u> Middle <u>ATKINS</u> Last <u>POORE</u>		4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 11, 1913</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
10a. BIRTH PLACE (County & State, or foreign country) <u>USA</u>		11. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
12. FATHER'S NAME <u>Robert Poore</u>		13. MOTHER'S MAIDEN NAME <u>Johna</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		15. SOCIAL SECURITY NO. <u>217-05-5594</u>	
16. INFORMANT <u>Hospital Records</u>		Address <u>Hospital Records</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the liver with ascites</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
19a. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		19b. INJURY OCCURRED while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		19d. (City or town) (County) (State) <u></u>	
20. I certify that (I) (this hospital) attended the deceased from <u>9-7</u> , 19 <u>66</u> , to <u>9-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-15</u> , 19 <u>66</u> , and that death occurred at <u>6:40 A.M.</u> , from the causes and on the date stated above.			
21a. SIGNATURE <u>Ronald S. Fleischer</u>		21b. DATE SIGNED <u>9-16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RONALD S. FLEISCHER</u>		22d. ADDRESS <u>7411 RIGGS Rd. HYATTSVILLE, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 19, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		24b. REC'D BY REGISTRAR <u>Charles Judge</u>	
24c. ADDRESS <u>254 Carroll St. N.W. Washington, D.C.</u>		24d. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>SEP 13 1966</u>			



## CERTIFICATE OF DEATH

13014

1. PLACE OF DEATH a. COUNTY <i>Thurgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>Washington, D. C.</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Randolph Hills Nursing Home</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Washington, D. C.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D. C.</i> d. STREET ADDRESS <i>3355 -16th St. N. W. Apt. 201</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Nellie W. Powell</i>		4. DATE OF DEATH Month Day Year <i>Sept 1 1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 3, 1876</i>
9. AGE (In years last birthday) <i>90</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerical</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Kingston, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Nelson Powell</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Smallwood</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Nursing Home Records same as #1</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung with</i> DUE TO (b) <i>Generalized Metastases</i> DUE TO (c) <i>2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1963</i> to <i>Sept 1, 1966</i> , that (I) (we) last saw the deceased alive on <i>Aug 31, 1966</i> , and that death occurred at <i>4:45 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Theodore J. Abernethy</i>		22b. DATE SIGNED <i>9-1-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Theodore J. Abernethy, M.D.</i>		22d. ADDRESS <i>916-19th St. N.W. Washington D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>9/3/66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Forty F rt, Pennsylvania</i>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>The S. H. Hines Company</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 3 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13015

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hospital</u>		d. STREET ADDRESS <u>8606 11<sup>th</sup> Ave</u>	
3 NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>(WMM)</u> Last <u>Puner</u>		4 DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug. 15, 1886</u>
9 AGE (in years last birthday) <u>80</u> yrs		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11 BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12 CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13 FATHER'S NAME <u>Abraham Siegal</u>		14 MOTHER'S MAIDEN NAME <u>Rose Katz</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>Unknown</u>	17. INFORMANT <u>Hospital Records</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction.</u> DUE TO (b) <u>Coronary Occlusion.</u> DUE TO (c) <u>Cardio Vascular Disease - Severe.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Recent.</u> <u>Recent.</u> <u>Years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Rt. Hip.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in Nussing Home.</u>	
20c. TIME OF INJURY Hour <u>?</u> o m <u>9/18</u> p m <u>19 66</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nussing Home</u>	20f. (City or town) <u>Silver Spring</u> (County) <u>Mont.</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		22. DATE SIGNED <u>9/27/66</u>	
EXAMINER'S NAME (Type) <u>John S. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/28/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. Hebron Cem.</u>	23d. LOCATION (City or Town) <u>Flushing, N.Y.</u> (County) (State)
24. FUNERAL DIRECTOR <u>B. Nanyanah + Sons</u> ADDRESS <u>3501-14<sup>th</sup> St. N.W.</u>		25a. REC'D BY REGISTRAR <u>SEP 23 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

3 22

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13016

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN It <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7509 Jackson ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>CHESTER WILLIAM RAUCH</u> First Middle Last 4 DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1966</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>5-20-06</u> 9. AGE (In years last birthday) <u>60</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal</u> 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) <u>Penna.</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Irving Rauch</u> 14 MOTHER'S MAIDEN NAME <u>Caroline</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16 SOCIAL SECURITY NO 17 INFORMANT <u>Mr. David Giacavaga</u> Address <u>2290 Highland Rd. AP. Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute asphyxiation due to</u> DUE TO (b) <u>massive aspiration of gastric contents</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Deceased vomited and aspirated vomitus.</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7:15</u> pm <u>9-30</u> 1966 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> 20f. (City or town) <u>Hyattsville</u> (County) <u>Pr. Geo.</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Leap</u> M.D. EXAMINER'S NAME (Type) <u>BELDEN R. LEAP M.D.</u>		22. DATE SIGNED <u>9-30-1966</u> Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Oct. 3-1966</u> 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY <u>Takoma Park Memorial</u> 23d. LOCATION (City or Town) (County) (State) <u>Penn.</u>		24. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>254 Birch St.</u> 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles J. Edge</u> DATE <u>OCT 3 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3-23

1301

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				d. STREET ADDRESS <u>1034 Welsh Drive</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard M. Ream</u>				4. DATE OF DEATH Month Day Year <u>Sept 16 1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 9, 1925</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u>		11. IF UNDER 24 HRS. Hours <u>7</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dir. of Transp.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mont. Co. Schools</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Washington DC</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Addison Carl Ream</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Sullivan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>				16. SOCIAL SECURITY NO. <u>579-24-4670</u>		17. INFORMANT <u>Doris E. Ream</u> Address <u>Same as Item 2.</u> <u>Wife</u> <u>ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Oedonocarcinoma metastatic to neck, chest &amp; ovules</u> (b) <u>Primary site undetermined</u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1966</u> to <u>16 Sept 1966</u> that (I) (we) last saw the deceased alive on <u>16 Sept 1966</u> and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph F. Schanno</u> M.D.				22b. DATE SIGNED <u>16 Sept 66</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH F. SCHANNO</u>				22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-19-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>SEP 20 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
3024						CERTIFICATE OF DEATH			13018		
1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>19 Mo 20 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH SANITARIUM &amp; HOSP</u>						2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>New Hampshire Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF <u>CORA M. REAMY</u> (Type or print)						4. DATE OF DEATH <u>9</u> <u>10</u> <u>19</u> <u>66</u>					
5 SEX <u>F</u>		6 COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>11-16-88</u>		9 AGE (n years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11 BIRTHPLACE (County & State, or foreign country) <u>VA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>BUSHROD MINOR</u>						14. MOTHER'S MAIDEN NAME <u>ALTHEA</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>				16 SOCIAL SECURITY NO <u>XXXXXX</u>		17 INFORMANT <u>John J. Reamy</u> <u>1508 Quebec St. Hyattsville, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO <u>190X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia, acute, type undetermined</u> DUE TO <u>24 hrs</u> (c) <u>Fat</u>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Platy degeneration of heart</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 10</u> , 19 <u>66</u> , to <u>Sept 11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 11</u> , 19 <u>66</u> , and that death occurred at <u>7P</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>W. W. Eastman</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-11-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. W. Eastman</u>						22d. ADDRESS <u>831 University Blvd., S. S., Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sep. 13, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Switland, Maryland</u>			
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>						ADDRESS <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13019

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wheaton Nursing Home 11901 Georgia Ave.</u>		d. STREET ADDRESS <u>3101 Woodley Road, N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Bessie Moorhead Reed</u>		4. DATE OF DEATH <u>9 23 1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-21-'83</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Park</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bowerman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Arllington, Va.</u>	
17. INFORMANT <u>Mrs. Annis Burroughs, 3232 N. Woodson St.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR THROMBOSIS</u> DUE TO (b) <u>DIABETIS MELLITUS</u> DUE TO (c) <u>IMMED. MONTHS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>65</u> to <u>Sept 23, 1966</u> , that (I) ( <u>was</u> ) last saw the deceased alive on <u>22 Sept 1966</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Walter Goodit</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WALTER GOODIT</u>		22d. ADDRESS <u>2390 GLENMONT CIR WHEATON MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/27/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. Gawler's Sons, Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1966</u> 25b. REGISTRAR'S SIGNATURE <u>John C. Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician's office. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**UNITED STATES DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13-26

13020

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
c. LENGTH OF STAY IN 1b <b>10 years</b>		d. STREET ADDRESS <b>10703 Lorain Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10703 Lorain Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leonora</b> Middle <b>Cecelia</b> Last <b>Reed</b>		4. DATE OF DEATH Month <b>September</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11, 1903</b>
9. AGE (in years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Portsmouth, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Oscar W. Reed, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Isabel S. Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>Oscar W. B. Reed, Jr.</b>		Address <b>208 Northwest Terrace Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>4 da.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1966</b> to <b>Sept 8, 1966</b> that (I) (we) lost the deceased alive on <b>Sept 6, 1966</b> and that death occurred on <b>Sept 8, 1966</b> at <b>5 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>SEP 13 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. B. Quattle M.D.</b>		22d. ADDRESS <b>1822 Biltmore St NW Washington D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sep. 10, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Clark E. Wison</b> <b>Warner E. Pumphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



CERTIFICATE OF DEATH

13021

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>8615 Mayfair Pl.</u>	
3 NAME OF DECEASED (Type or print) First <u>Endel</u> Middle <u>Rennit</u> Last e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4 DATE OF DEATH Month <u>5</u> , Day <u>Sept</u> , Year <u>66</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-30-1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Producer &amp; Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>	9. AGE (In years last birthday) <u>55</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>Estonia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>- - -</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	
17 INFORMANT <u>Esther Rennit - See Item No. 2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>- - -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NO</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>15 60</u> , 19 <u>66</u> , to <u>9-3</u> , 1966, that (I) (we) last saw the deceased alive on <u>5-31</u> , 19 <u>66</u> , and that death occurred at <u>2:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Veronika Troost</u> M.D.		22b. DATE SIGNED <u>9-5-1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>VERONIKA TROOST</u>		22d. ADDRESS <u>10236 N. H. Ave. Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>9-10-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gdulars Sons</u>		25a. REC'D BY REGISTRAR <u>WASH. D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 9 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>3811 RALPH ROAD.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES</u> <u>ROBBINS</u>		4 DATE OF DEATH Month Day Year <u>9</u> / <u>20</u> 19 <u>66</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/13/19</u>
9 AGE (In years last birthday) <u>69</u> yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13 FATHER'S NAME <u>ISRAEL SIKERMAN</u>	
14 MOTHER'S MAIDEN NAME <u>JENNIE</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16 SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MONROE ROBBINS SAMEETS 20</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>66</u> , to <u>Sept 20</u> , 19 <u>66</u> , that (I) <u>did</u> <del>did not</del> saw the deceased alive on <u>Sept 20</u> , 19 <u>66</u> , and that death occurred on <u>Sept 20</u> , 19 <u>66</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Michael Dobridge</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Michael Dobridge</u>		22d. ADDRESS <u>12600 Parkside Dr. Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-21-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LETH DAVID CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>ELMONT, L.I. N.Y.</u>
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1966</u>	
ADDRESS <u>4217 - 75th St. N.Y.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Michael Dobridge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



In Reap called & cleared case  
9/2/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

APP

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13023

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>14 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> d. STREET ADDRESS <u>13014 FREELAND ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAURICE Joseph ROCHE</u>	4. DATE OF DEATH Month Day Year <u>9 2 1966</u>	5. SEX <u>MALE</u> 6. COLOR OR RACE <u>Wh.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor Naval O. Laboratory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVAL O. Laboratory</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Roche</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Martine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Anna Catherine Roche</u> Address <u>13014 Freeland Rd. Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>4331</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATRIAL FIBRILLATION</u> DUE TO (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DIS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>UNKNOWN</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>63</u> , to <u>9-1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-1</u> , 19 <u>66</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Walter E. Goetz</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WALTER E. GOETZ MD</u>		22d. ADDRESS <u>2390 GLENMONT CIR WHEATON MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 6, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

13030

13024

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Virginia</b> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c LENGTH OF STAY IN 1b <b>29 days</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		e STREET ADDRESS <b>7424 Bethune Street</b>	
3 NAME OF DECEASED (Type or print) <b>Ivan</b>		4 DATE OF DEATH Month <b>September</b> Day <b>29</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 May 1893</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR Months <b>73</b> Days	11. IF UNDER 24 HRS Hours <b>73</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Poltara, Ukraina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ivan ROMANENKO</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>560 42 7470</b>	
17. INFORMANT <b>Charles C. SPOONER Jr. for 7424 Bethune St.</b>		18. <b>Mrs. Fekla P. ROMANENKO / Falls Church, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Encephalopathy</b> <b>1318</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>31 August, 1966</b> , to <b>29 September 1966</b> that (we) last saw the deceased alive on <b>29 September 1966</b> , and that death occurred at <b>3:45 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>J. C. BAXTER, LCDR MC USN</b>		22b. DATE SIGNED <b>1966 29 September</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. C. BAXTER, LCDR MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/3/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>
24. FUNERAL DIRECTOR <b>Falls Church Funeral Home</b>		25a. REC'D BY REGISTRAR <b>OCT 5 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles C. Spooner Jr.</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13025

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>4 hrs 32 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington San + Hospital</u>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>8309 Garland Ave #1</u>	
3 NAME OF DECEASED (Type or print) <u>William Frederick Dale Roubesh</u> First Middle Last		4 DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1966</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-16-36</u> 9 AGE (In years last birthday) <u>30</u> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Traffic De-Dept of Highways</u>		11 BIRTHPLACE (State or foreign country) <u>Indiana</u>	
13 FATHER'S NAME <u>Dale Roubesh</u>		14 MOTHER'S MAIDEN NAME <u>Esther Iona Deal</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>317-38-2045</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gunshot wound in forehead, apparently self-inflicted</u> DUE TO (b) <u>forehead, apparently self-inflicted</u> DUE TO (c) <u>self-inflicted</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Deceased shot self in head</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased shot self in head</u>	
20c TIME OF INJURY Month Day Year <u>Sept 5 1966</u>		20d INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>		20f (City or town) <u>Takoma Park</u> (County) <u>Montgomery</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.		22. DATE SIGNED <u>Sept 5, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>		Address (Street, city, town, county) <u>Washington, DC</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		23b DATE THEREOF <u>9/7/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Scottsburg, Indiana</u>		23d LOCATION (City or Town) (County) (State)	
24 FUNERAL DIRECTOR <u>The S. H. Hines</u> Address <u>Washington, DC</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>SEP 8 1966</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13026

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN ID <u>3 weeks</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>				e. STREET ADDRESS <u>95 E. WAYNE AVE</u>			
3. NAME OF DECEASED (Type or print) <u>BARTHOLOMEW Miles RYAN</u>				4. DATE OF DEATH <u>SEPTEMBER 21 1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/9/05</u>	
9. AGE (in years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker - AL</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MEAT BROKER</u>			
13. FATHER'S NAME <u>John Ryan</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-09-5220</u>		17. INFORMANT <u>Mrs. Gloy C. Ryan</u>		Address <u>95 East Wayne Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1621 Bronchogenic Carcinoma (R) lung &amp; gen. metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal G.I.T. hemorrhage</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-30</u> , 19 <u>66</u> to <u>9-21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-21</u> , 19 <u>66</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>J.W. Peabody Jr. / V. de Guzman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-21-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J.W. Peabody Jr. / V. de Guzman</u>				22d. ADDRESS <u>1234 19th NW Wash DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sep. 24, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>				ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 26 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

پیشرفت کار

در سال ۱۳۴۵

در این سال، کارهای مختلف انجام شده است و نتایج آن به شرح زیر است:

13033

CERTIFICATE OF DEATH

13027

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If a please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>507 Dartmouth Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mr. John Thomas Ryder</b> First Middle Last		4. DATE OF DEATH <b>September 19 19 66</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1905 July 24 1905</b> 9. AGE (In years last birthday) <b>61</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Sales Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Army times Pub. Co. Ohio</b>	
11. BIRTHPLACE (County & State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13. FATHER'S NAME <b>Charles M. Ryder</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ralston</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes army WW II</b>		16. SOCIAL SECURITY NO. <b>276-10-6168</b>	
17. INFORMANT <b>Violet E. Ryder</b> <b>507 Dartmouth Ave. Silver Spring, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per one for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of liver</b> 1528 Conditions, if any which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Primary carcinoma of colon</b> (c) <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 12, 1966</b> , to <b>Sept 19, 1966</b> that (I) (we) last saw the deceased alive on <b>Sept 18, 1966</b> , and that death occurred at <b>1:50 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Eino Magy</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>EINO MAGY</b>		22d. ADDRESS <b>831 University Blvd. E., Silver Sp., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sep. 21, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>C. Glen Carter</b> <b>Warner E. Humphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>SEP 27 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

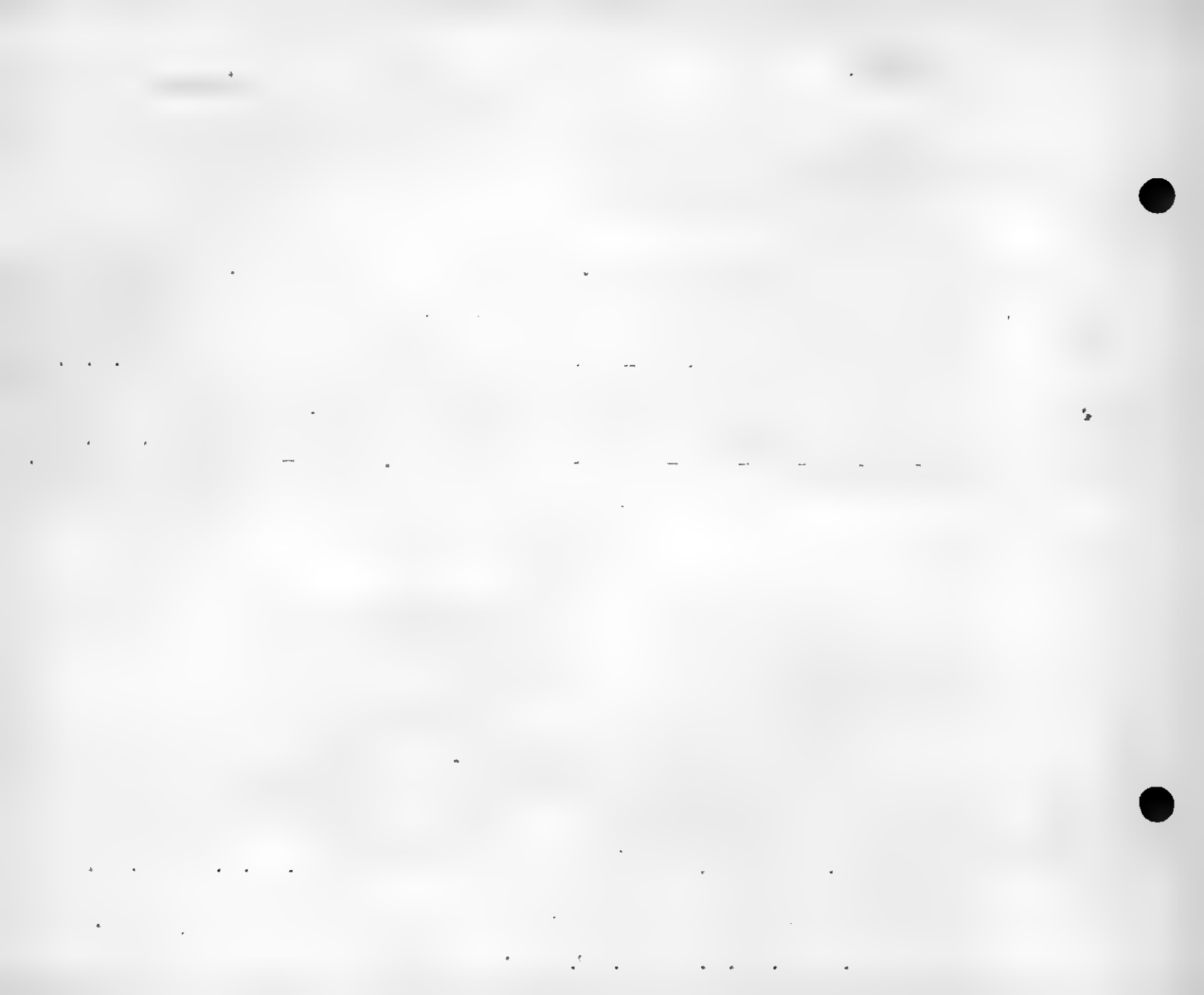
13034

130124

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>Chevy Chase</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4119 Rosemary Street</b>		2. USUAL RESIDENCE (Where deceased lived, if institution residents before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>4119 Rosemary XXXX Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARE</b> Middle <b>W.</b> Last <b>STAFFORD</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>14</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-30-1868</b>
9. AGE (In years last birthday) <b>97</b> yrs		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>14</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Decius Wade</b>		14. MOTHER'S MAIDEN NAME <b>Bernice Galpin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>- - -</b>		16. SOCIAL SECURITY NO. <b>- - -</b>	
17. INFORMANT <b>Bernice S. Pratt</b>		Address <b>Chevy Chase, Md. 4119 Rosemary St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gastrointestinal Bleeding</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Unknown cause.</b> DUE TO (c) <b>- - -</b>			INTERVAL BETWEEN ONSET AND DEATH <b>one day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>- - -</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>- - -</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>- - -</b>	20f. (City or town) (County) (State) <b>- - -</b>
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>66</b> , to <b>13 Sept 1966</b> that (I) (we) last saw the deceased alive on <b>13 Sept 1966</b> and that death occurred at <b>3 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>David R. Lawrenz</b>		22b. DATE SIGNED <b>14 Sept. 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. David R. Lawrenz</b>		22d. ADDRESS <b>2001 Eye St. N.W. Wash. DC.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>9-16-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grand View Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Chillicothe Ohio.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		25a. REC'D BY REGISTRAR <b>SEP 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13029

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>1812 Mc Auliffe Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Douglas Lee SANDERS</b>				4 DATE OF DEATH Month Day Year <b>September 15 19 66</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Cauc.</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 12, 1966</b>		9 AGE (n years lost birthday) yrs <b>3</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11 BIRTHPLACE (County & State or foreign country) <b>Bethesda, Montgomery, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Richard L. Sanders</b>				14 MOTHER'S MAIDEN NAME <b>Shirley Luckett</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO <b>None</b>		17 INFORMANT <b>Dr. Rockville</b> Address <b>Md.</b> <b>Mr. Richard L. Sander, 1812 Mc Auliffe</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive Subarachnoid Hemorrhage</b> <b>7600</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ (c) _____ DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (x) (this hospital) attended the deceased from <b>Sept. 12, 1966</b> to <b>Sept. 15, 1966</b> that (x) (we) last saw the deceased alive on <b>Sept. 15, 1966</b> , and that death occurred at <b>735 P.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Jerry J. Tomasovic</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Sept. 16, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jerry J. Tomasovic, M. D.</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-10-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>R. A. Pumphrey Funeral Home</b> <b>7557 Wisconsin Ave. Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 20 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13036

CERTIFICATE OF DEATH

13030

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>7723 Eastern Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs Marie Christine Satterfield</u>		4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years, last birthday) <u>60</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Des Moines, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bondor</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>James R. Satterfield (Same as # 2)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 465X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ANOXIA</u> (c) <u>MASSIVE PULMONARY EMBOLUS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES, MELLITUS, CORONARY ARTERY DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>9-26</u> , 19 <u>66</u> , to <u>9-28</u> , 19 <u>66</u> that (1) (we) last saw the deceased alive on <u>9-28</u> , 19 <u>66</u> , and that death occurred at <u>10:00</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>John L. Ford</u>		22b. DATE SIGNED <u>9-28-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN LOUIS FORD MD</u>		22d. ADDRESS <u>831 UNIVER. BLVD E SILVER SPRING</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sep. 30, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 3 1966</u>	
<u>Wanner E. Humphrey, Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Judge</u>	



Cleared by Medical Examiner  
Dr. John Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13031

13031

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		d. STREET ADDRESS <b>6919 24th Ave</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium + Hosp</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Earl Peter Scheuring</b>		4. DATE OF DEATH Month Day Year <b>9 10 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-14-16</b>
9. AGE (In years last birthday) <b>50</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Equipment Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Reading, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christian Scheuring</b>		14. MOTHER'S MAIDEN NAME <b>Esther O'Toole</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W.II</b>		16. SOCIAL SECURITY NO. <b>170 05 9287</b>	
17. INFORMANT <b>Anne Scheuring</b>		Address <b>6919 24th Ave Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>CORONARY ATHEROSCLEROSIS</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-5-</b> , 19 <b>66</b> , to <b>8-13-</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>8-13-</b> , 19 <b>66</b> , and that death occurred on <b>7:50 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Oliver B. Bond</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>OLIVER B. BOND</b>		22d. ADDRESS <b>6872 RIVERDALE ROAD LANHAM MD 20801</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/15/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>SEP 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13032									
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY in 1b <b>1 mo. 5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>11604 LOCKWOOD DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>B.</b> Last <b>SCHNEIDER</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>3</b> Year <b>1966</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-14-66</b>		9. AGE (In years last birthday) <b>19</b> IF UNDER 1 YEAR: Months <b>7</b> Days <b>19</b> IF UNDER 24 HRS: Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>M.D.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		
13. FATHER'S NAME <b>JOHN R SCHNEIDER</b>					14. MOTHER'S MAIDEN NAME <b>BONNIE BROADT</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>JOHN R. SCHNEIDER SAMEAS (2D)</b> Address <b></b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METABOLIC ACIDOSIS DUE</b> DUE TO <b>to UNDETERMINED CAUSE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b></b> DUE TO <b></b> (c) <b></b>								INTERVAL BETWEEN ONSET AND DEATH <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b></b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b></b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>		
21. I certify that (I) (this hospital) attended the deceased from <b>7/27</b> , 19 <b>66</b> , to <b>9/3</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/2</b> , 19 <b>66</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Herbert J. Jacobs MD</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Sept 3, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>HERBERT J. JACOBS</b>					22d. ADDRESS <b>HOLY CROSS HOSPT SILVER SPRING MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9-7-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL</b>		23d. LOCATION (City, town or county) (State) <b>FTMYER, VA.</b>			
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO 8655 GA AVE SILVER SPRING MD</b>						25a. REC'D BY REGISTRAR <b>SEP 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13033

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>		c. LENGTH OF STAY in 1b <i>D.O.A.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>127 Hesketh St.</i>		d. STREET ADDRESS <i>127 Hesketh St.</i>	
3 NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Schneider</i> Last		4 DATE OF DEATH Month <i>9</i> Day <i>11</i> Year <i>1966</i>	
5 SEX <i>F</i>	6 COLOR OR RACE <i>Can</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>March 14 1900</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Architect</i>		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <i>66 yrs</i>
11 BIRTHPLACE (Store or foreign country) <i>Budapest Austria</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13 FATHER'S NAME <i>Zubanik</i>		14 MOTHER'S MAIDEN NAME <i>Bozana Vana</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO	
17 INFORMANT <i>Joseph Z. Schneider</i>		Address <i>same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute intoxication from overdose of alcohol</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) <i>Chronic alcoholism</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Took too large a dose of alcohol</i>	
20c. TIME OF INJURY Month, Day, Year <i>5:00 pm 9/11 1966</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Montgomery Md.</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John es. Ball</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>9/12/66</i>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>	23b. DATE THEREOF <i>13 Sept 66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	23d. LOCATION (City or Town) (County) (State) <i>Southland, P.G., Md.</i>
24. FUNERAL DIRECTOR <i>Robert A. Rumphrey, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 15 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



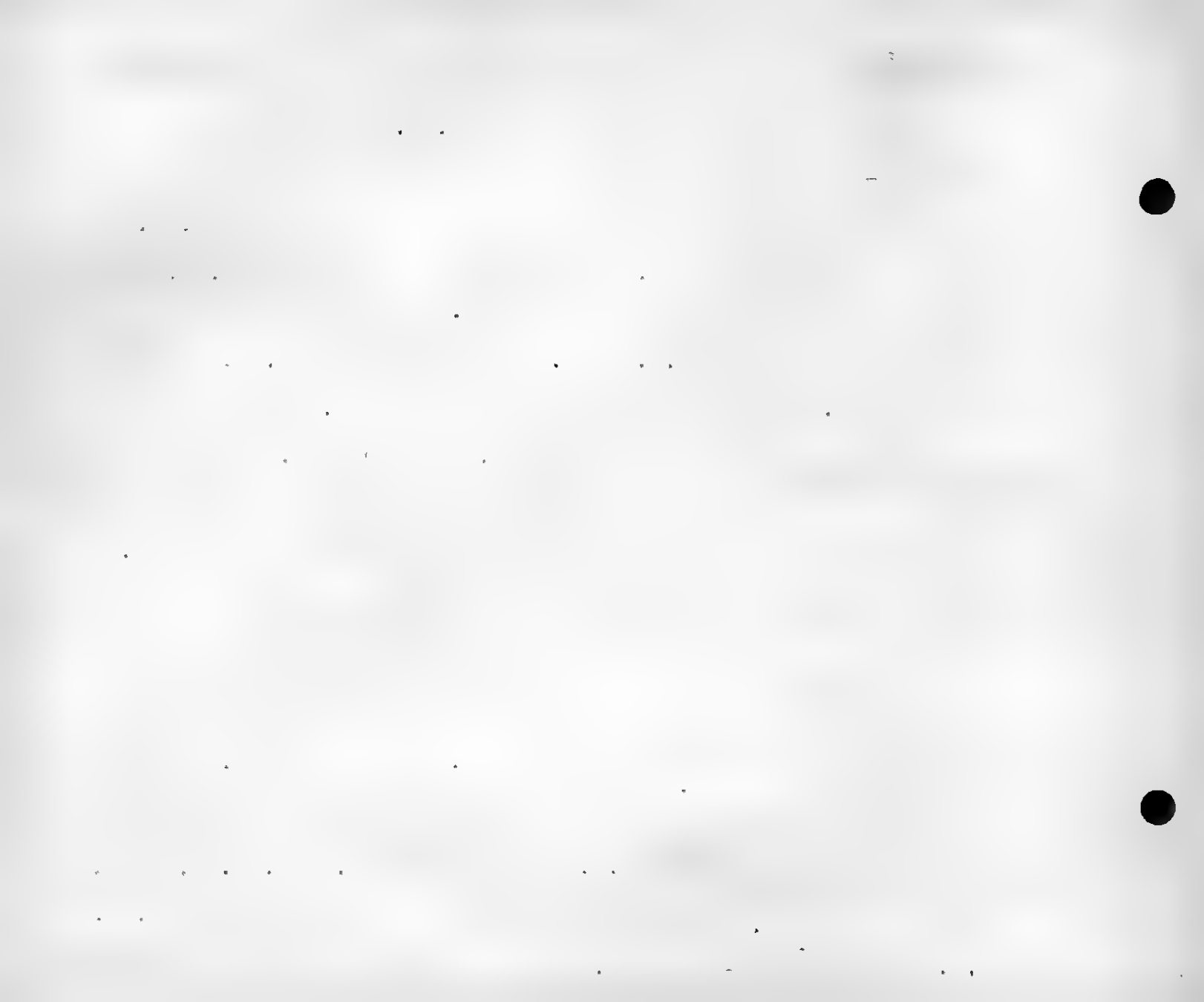
## CERTIFICATE OF DEATH

13034

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda-Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>3 months</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5203 Murray Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2800 Woodley Road N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nora K. Schrider</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>3</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1894</b>
9. AGE (In years) <b>72</b> yrs		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Hours <b>19</b> Min <b>19</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		12. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>Maurice J. Keane</b>		16. MOTHER'S MAIDEN NAME <b>Mary A. Whelan</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO. <b>no</b>	
19. INFORMANT <b>Mrs. Marguerite K. Greene same as #1</b>		Address	
19. MEDICAL CERTIFICATION			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Primary Carcinoma of Stomach</b> DUE TO (c) <b>Metastasis to Liver &amp; Gall Bladder</b> INTERVAL BETWEEN ONSET AND DEATH <b>Since Jan. 16, 1965</b> <b>3 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 16, 1965</b> to <b>Sept. 3, 1966</b> that (I) (we) lost saw the deceased alive on <b>Sept. 3, 1966</b> and that death occurred on <b>12/50</b> from causes and on the date stated above.			
22a. SIGNATURE <b>James Hawfield</b>		22b. DATE SIGNED <b>9.9.66</b>	
22c. PHYSICIAN'S NAME (Type) <b>James Hawfield M.D.</b>		22d. ADDRESS <b>1150 Conn. Ave. N. W. Wash. DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept. 7, 1966</b>	23c. NAME OF CEMETERY OR REPOSITORY <b>Mount Olivet</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>
24. FUNERAL DIRECTOR <b>F. J. Collins</b>		25a. REC'D BY REGISTRAR <b>SEP 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>3821 - 14th St. NW WashDC</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

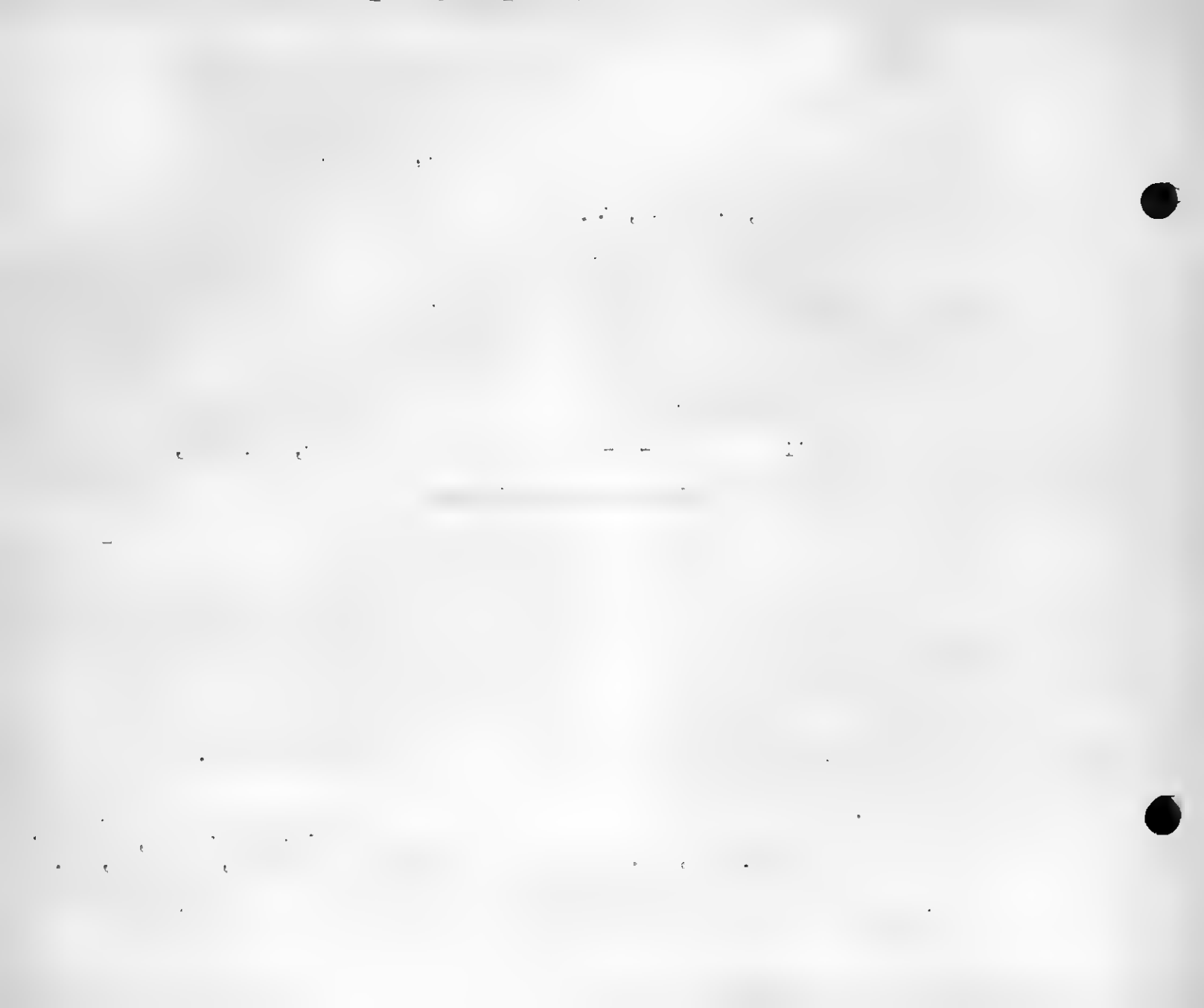
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH 13035

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
c. LENGTH OF STAY IN 1b <b>115 Days</b>		d. STREET ADDRESS <b>9510 Seminole Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eugene</b> Middle <b>Joseph</b> Last <b>Schubert</b>		4. DATE OF DEATH Month <b>September</b> Day <b>17</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 July 1919</b>
9. AGE (in years last birthday) <b>47</b> yrs.		10. BIRTHPLACE (County & State, or foreign country) <b>New York</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Schubert</b>		14. MOTHER'S MAIDEN NAME <b>Helen Schwartz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 11 130-07-1072</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Carcinoid Tumor</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Small Bowel obstruction</b> DUE TO (c) <b>Uremia</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>8 Years</b> <b>3-4 Months</b> <b>1 Week</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>25 May</b> , 19 <b>66</b> , to <b>17 Sept.</b> , 19 <b>66</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>17 Sept.</b> , 19 <b>66</b> , and that death occurred at <b>5:55 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert Zelis</b>		22b. DATE SIGNED <b>17 September 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert Zelis, MD.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/20/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cemetery Arlington, Virginia</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>St. NW, Wash. D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>SEP 20 1966</b>		25c. DATE <b>SEP 20 1966</b>	

*Charles Judge*



## CERTIFICATE OF DEATH

13036

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN TB <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hospital</u>		d. STREET ADDRESS <u>8609 GREENWOOD AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MOLLIE Nm</u>	First <u>MOLLIE</u> Middle <u>Nm</u> Last <u>SEIGEL</u>	4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-25-05</u>
9. AGE (In years last birthday) <u>61</u> yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>UNKNOWN</u>	14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u></u>	16. SOCIAL SECURITY NO <u>NONE</u>	17. INFORMANT <u>Mrs. Herbert J. Aiken</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>ASVD</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, H.U. Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>July</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 12</u> , 19 <u>66</u> , and that death occurred at <u>12:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Marvin Schneider</u>		22b. DATE SIGNED <u>9/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Marvin Schneider</u>		22d. ADDRESS <u>911 S. 1st St. Springfield, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-18-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>HYATTSVILLE PG. MD</u>
24. FUNERAL DIRECTOR <u>GOLDRECK FUNERAL HOME 4217 GRANT ST. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 19 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13037

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>			
c. LENGTH OF STAY IN 1b <u>13 days</u>				d. STREET ADDRESS <u>14204 Derrington Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Mary Cross</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DAPHNE</u> Middle <u>E</u> Last <u>SHAIBE</u>				4. DATE OF DEATH Month <u>9</u> Day <u>6</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/14/63</u>	9. AGE (In years last birthday) <u>2</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MAC SHAIBE</u>				14. MOTHER'S MAIDEN NAME <u>MARY BECKENWALD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MAC SHAIBE Same as 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarcts, right occipital (remote)</u> DUE TO <u>and left parietal (recent) lobes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aortic stenosis</u> (c) <u>Downs syndrome</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/29</u> , <u>1966</u> , to <u>9/6</u> , <u>1966</u> , that (I) (we) last saw the deceased alive on <u>9/6</u> , <u>1966</u> , and that death occurred at <u>4:40 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald Straus</u>				22b. DATE SIGNED <u>9/6/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Donald Straus</u>	
22d. ADDRESS <u>4301 Aspen Hill Road</u>				22e. CITY, STATE, AND ZIP <u>Rockville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>9-9-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Goldberg Funeral Home 4217-9th St. N.W.</u>				25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

13038

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>5 hrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		d. STREET ADDRESS <u>7927 Chicago Ave., Apt 102</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. &amp; HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VICTORIA</u> Middle <u>EVA</u> Last <u>SHERMAN</u>		4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>FE</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/7/19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Dept</u>	9. AGE (In years last birthday) <u>47</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HOMER SHERMAN</u>		14. MOTHER'S MAIDEN NAME <u>EVA MARDRES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.H.D. &amp; Congestive heart failure</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>62</u> to <u>8/7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/7</u> , 19 <u>66</u> , and that death occurred at <u>8 P</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>Herbert Wechsler MD</u>		22b. DATE SIGNED <u>8/8/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Herbert Wechsler MD</u>		22d. ADDRESS <u>1800 Eye St N.W. Wash DC</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON D.C.</u>
24. FUNERAL DIRECTOR <u>LEE FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>SEP 14 1966</u>	
ADDRESS <u>300 4th ST NE</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CLEARED WITH MEDICAL EXAMINER DR REAP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



VR A15 (4)  
20M 1/65

1. PLACE OF DEATH a. COUNTY <div>Montgomery</div>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <div>Maryland</div>		b. COUNTY <div>Prince Georges</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div>Bethesda</div>		c. LENGTH OF STAY in 1b <div>23 Days</div>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div>West Hyattsville</div>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div>The Clinical Center, Bethesda, Maryland</div>				d. STREET ADDRESS <div>7413 17th Avenue</div>	
3. NAME OF DECEASED (Type or print) <div>Thomas</div>		First <div>Edward</div>		Middle <div>Shields</div>	
5. SEX <div>Male</div>		6. COLOR OR RACE <div>White</div>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>	
8. DATE OF BIRTH <div>2 July 1930</div>		9. AGE (In years last birthday) <div>36</div>		10. IF UNDER 1 YEAR Months <div> </div> Days <div> </div> Hours <div> </div> Min. <div> </div>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div>Photo rapher</div>		10b. KIND OF BUSINESS OR INDUSTRY <div>News Service</div>		11. BIRTHPLACE (County & State, or foreign country) <div>Washington, DC</div>	
12. CITIZEN OF WHAT COUNTRY? <div>USA</div>		13. FATHER'S NAME <div>Vincent Shields</div>		14. MOTHER'S MAIDEN NAME <div>Kathryn Sheldon</div>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <div>No</div>		16. SOCIAL SECURITY NO. <div>578-28-3618</div>		17. INFORMANT <div>The Medical Record Address</div>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div>Cor Pulmonale</div> <div>1 X</div> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <div>Pulmonary Fibrosis</div> DUE TO (c) <div>Hodgkins Disease</div>		INTERVAL BETWEEN ONSET AND DEATH <div>1 Year</div> <div>4-5 Years</div> <div>8 Years</div>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <div> </div> p.m. <div>19</div>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (X) (this hospital) attended the deceased from <div>September 1, 19 66</div> to <div>Sept. 24, 19 66</div> , that (I) (we) last saw the deceased alive on <div>Sept 24</div> 19 66, and that death occurred at <div>1:30 M.</div> from the causes and on the date stated above.					
22a. SIGNATURE <div>Martin H. Cohen</div>		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <div>24 Sept. 1966</div>	
22c. PHYSICIAN'S NAME (Type) <div>Martin H. Cohen, MD.</div>		22d. ADDRESS <div>The Clinical Center, National Institutes of Health, Bethesda, Md.</div>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <div>Sept 28-66</div>		23b. DATE THEREOF <div>Sept 28-66</div>		23c. NAME OF CEMETERY OR CREMATORY <div>Bethesda National Cemetery</div>	
23d. LOCATION (City, town or county)		(State)		23e. REC'D BY REGISTRAR <div>SEP 27 1966</div>	
24. FUNERAL DIRECTOR <div>Arthur Walters</div>		ADDRESS <div>254 Carroll St</div>		24b. REGISTRAR'S SIGNATURE <div>James Judge</div>	



## CERTIFICATE OF DEATH

13040

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY in lb <b>9 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b> d. STREET ADDRESS <b>RT. 3</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLIE</b> Middle <b>BRITTON</b> Last <b>SHRADER</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>14</b> Year <b>19 66</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/17/07</b>	
9. AGE (In years last birthday) <b>58 59</b> yrs		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>JOSEPH SHRADER</b>				14. MOTHER'S MAIDEN NAME <b>NELLIE ASBURY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>229-18-1578</b>		17. INFORMANT <b>HOSPITAL RECORDS,</b> Address <b>OLNEY, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>Coronary Artery Disease with myocardial infarction 8 days ago.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Emphysema.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/12/66</b> , 19 <b>66</b> , to <b>9/14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/14/66</b> , 19 <b>66</b> , and that death occurred at <b>4:00</b> A.M., from causes and on the date stated above.							
22a. SIGNATURE <b>Richard A. Yates</b>				22b. DATE SIGNED <b>9/14/66</b>		22c. PHYSICIAN'S NAME (Type) <b>RICHARD A. YATES, M.D.</b>	
22d. ADDRESS <b>OLD BALTIMORE RD., OLNEY, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>9-17-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resthaven Memorial Gardens, Frederick, Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Ernest C. Garther</b> ADDRESS <b>Gaithersburg, Md.</b>				25a. REC'D BY REGISTRAR <b>SEP 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

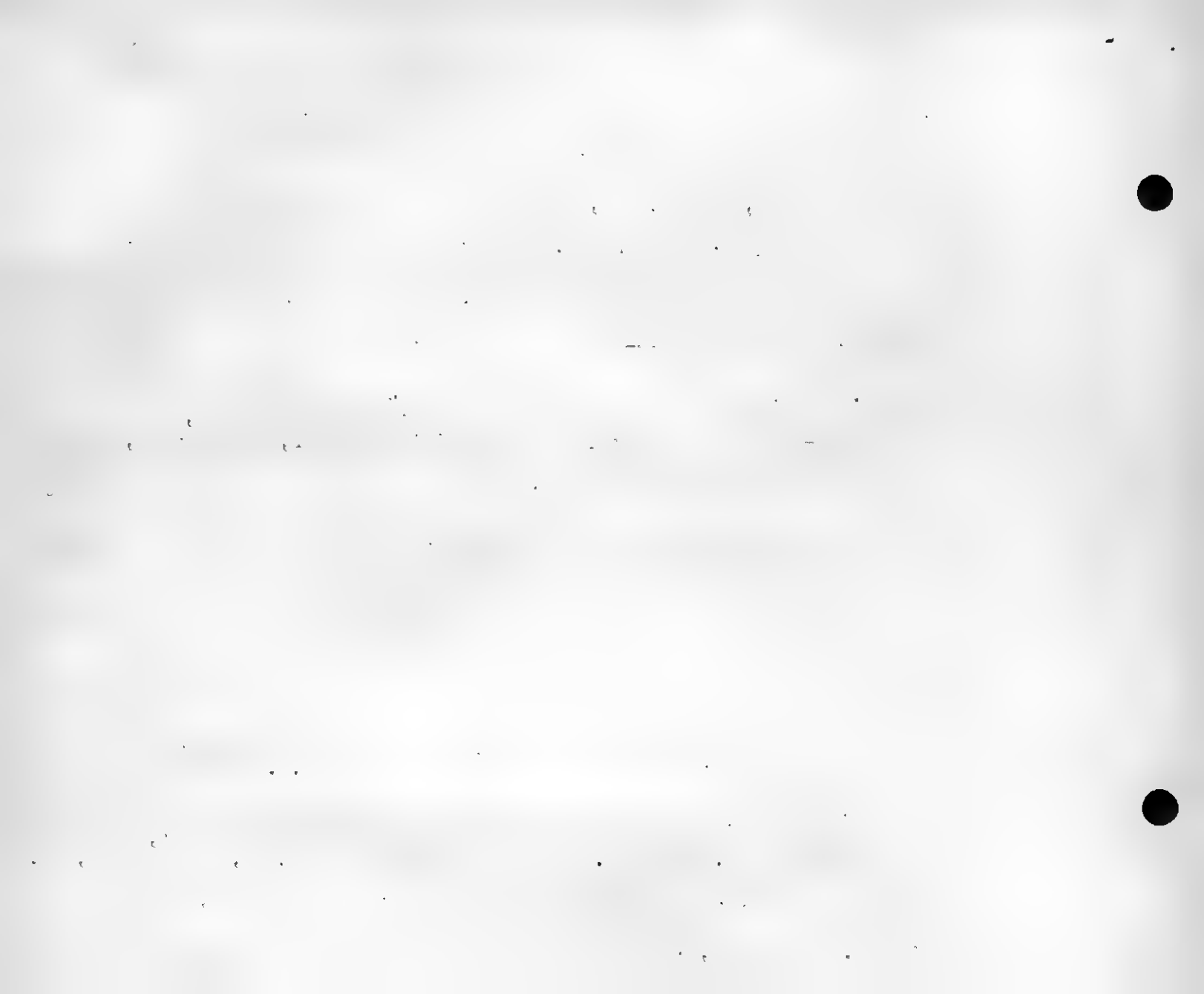
## CERTIFICATE OF DEATH

13041

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN ID <u>37 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Maryland</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Essex</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Essex Falls</u> d. STREET ADDRESS <u>295 Roseland Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Allen</u> Middle <u>Castelnau</u> Last <u>Siebens</u>		<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>24</u> Year <u>1966</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>5 December 1918</u>		<b>9. AGE</b> (In years last birthday) <u>47</u> yrs. IF UNDER 1 YEAR: Months <u>9</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Director</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>---</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Illinois</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Arthur T. Siebens</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Irene Westphal</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>1942-46</u>				<b>16. SOCIAL SECURITY NO.</b> <u>Not Available</u>		<b>17. INFORMANT</b> <u>The Medical Records, The Clinical Center, Bethesda 14, Maryland</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Hypernephroma</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 Minute</u> <u>7 Years</u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>							
<b>21. I certify that</b> <u>  </u> (this hospital) attended the deceased from <u>18 August 1966</u> to <u>24 September 1966</u> , that <u>  </u> (we) last saw the deceased alive on <u>24 September 1966</u> , and that death occurred at <u>3:04 A.M.</u> from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <u>Herbert E. Kann, MD.</u>												<b>22b. DATE SIGNED</b> <u>1966</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Herbert E. Kann, MD.</u>												<b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>				<b>23b. DATE THEREOF</b> <u>9-26-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Crematory</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Suitland, Maryland</u>					
<b>24. FUNERAL DIRECTOR</b> <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>												<b>25a. REC'D BY REGISTRAR</b> <u>SEP 27 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13042

1. PLACE OF DEATH a. COUNTY <u>Montgomery.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CONGRESSIONAL MANOR NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Langley Park, Sil Spring.</u> d. STREET ADDRESS <u>401-University Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>HELENA</u> Middle <u>P.</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 15, 1905</u>		9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>H-Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Calif.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Charles W. Parmelee</u>						14. MOTHER'S MAIDEN NAME <u>Loy J. Steele</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>yes-UNKNOWN</u>		17. INFORMANT <u>ALVAN M. Smith</u>				Address <u>Same as #2</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Paralysis</u> DUE TO (b) <u>Non-Malignant Brain Tumor</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>11+ yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 15, 1966</u> to <u>Sept 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 15, 1966</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.																			
22a. SIGNATURE <u>W H Clements</u>												22b. DATE SIGNED <u>Sept 16, 1966</u>							
22c. PHYSICIAN'S NAME (Type) <u>William H. Clements</u>												22d. ADDRESS <u>6001-35th Ave. Hyattsville Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9/20/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				23d. LOCATION (City, town or county) (State) <u>Arlington Va.</u>									
24. FUNERAL DIRECTOR <u>W.W. Chambers &amp; Co</u>												25a. REC'D BY REGISTRAR <u>SEP 19 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13043

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>29 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		e. STREET ADDRESS <u>3408 Greencastle Road</u>	
3 NAME OF DECEASED (Type or print) <u>Walter Harper Smith</u>		4 DATE OF DEATH <u>September 28 1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-9-70</u>
9 AGE (In years last birthday) <u>96 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Union Pacific RR - RAILROAD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Reed Smith</u>		14. MOTHER'S MAIDEN NAME <u>Roseella Puder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Spanish American War Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records - Washington San &amp; Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Failure</u> 4500 DUE TO (b) <u>Advanced Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Myelogenous Leukemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>66</u> to <u>9/28</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>9/28</u> , 19 <u>66</u> , and that death occurred at <u>6:57 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Smith, Jr.</u>		22b. DATE SIGNED <u>9/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Smith, Jr.</u>		22d. ADDRESS <u>Burtonsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10/3/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. HEBRON CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>UPPER MONTCLAIR, N.J.</u>
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS, INC. SILVER SPRING, MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 3 1966</u>	



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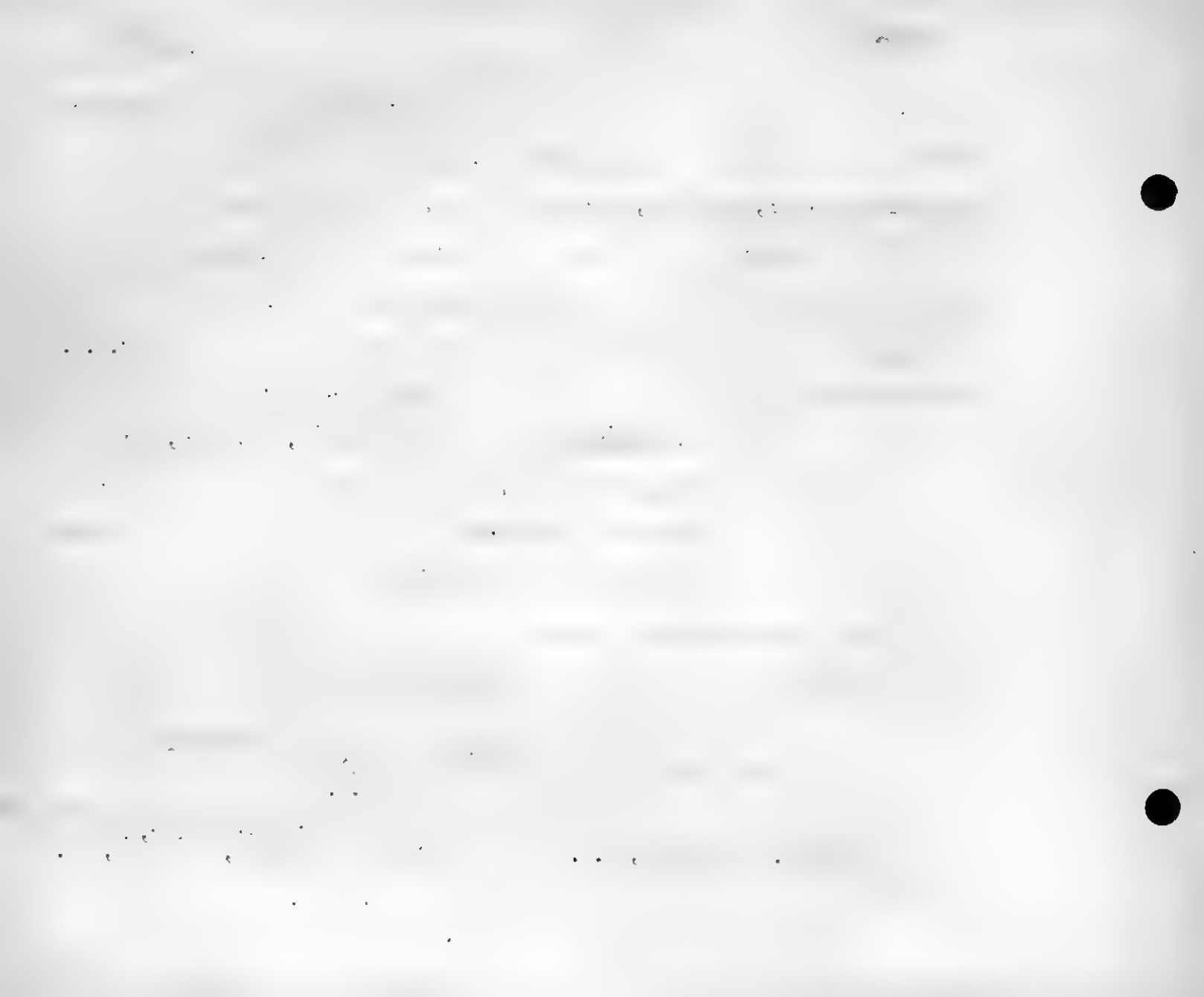
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13044

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>157 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b> d. STREET ADDRESS <b>11714 Castlewood Court</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maury</b> Middle <b>(None)</b> Last <b>Soltes</b>			4. DATE OF DEATH Month <b>September</b> Day <b>6</b> Year <b>1966</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>29 December 1930</b>		9. AGE (In years last birthday) <b>35</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Surgeon</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Soltes</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Rachefsky</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>463-527-298</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary sepsis unknown etiology</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Salmonella Septicemia</b> DUE TO (c) <b>Acute myelogenous leukemia</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 weeks</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Unknown heart disease 3 weeks</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>2 April</b> , 19 <b>66</b> , to <b>6 September 66</b> , that <b>we</b> (we) last saw the deceased alive on <b>September 6 1966</b> , and that death occurred at <b>1:17M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Joel J. Rubenstein</b>				22b. DATE SIGNED <b>6 September 1966</b>					
22c. PHYSICIAN'S NAME (Type) <b>Joel J. Rubenstein, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-8-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shearith Israel Cong. Cem. Dallas, Texas</b>		23d. LOCATION (City, town or county) (State) <b>Dallas, Texas</b>			
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b>				25a. REC'D BY REGISTRAR <b>3501 14th St. Washington DC</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>SEP 8 1966</b>	

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

13045

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA (rural)</b>		c. LENGTH OF STAY IN 1b <b>54 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dorothy Cuthbert SOWARD</b>		4. DATE OF DEATH <b>September 18</b> 19 <b>66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 16, 1901</b>
9. AGE (In years lost birthday) yrs. <b>65</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>2</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR <b>INDUSTRY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward MINNIS</b>		14. MOTHER'S MAIDEN NAME <b>Lillian BANNISTER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578 07 2373</b>	
17. INFORMANT <b>Morris S. SOWARD</b>		Address <b>Silver Spring, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, Pancreas</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>15 IX</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that <del>xx</del> (this hospital) attended the deceased from <b>July 25</b> , 19 <b>66</b> , to <b>Sept. 18</b> , 19 <b>66</b> that <del>xx</del> (we) last saw the deceased alive on <b>18 September 1966</b> , and that death occurred on <b>0129A</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>F. D. Keenan</b> M.D.		22b. DATE SIGNED <b>18 SEPT 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. D. KEENAN</b>		22d. ADDRESS <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/21/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>
24. FUNERAL DIRECTOR <b>R.A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>SEP 20 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13052

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13046

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Md.</b> b COUNTY <b>Mont.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c LENGTH OF STAY IN 1b <b>Rockville</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>100 W. Montgomery Avenue</b>		e STREET ADDRESS <b>100 W. Montgomery Ave.</b>	
3 NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>M.</b> Last <b>Spangler</b>		4 DATE OF DEATH Month <b>Sept.</b> Day <b>24</b> Year <b>1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7/1/1914</b>
9 AGE, years <b>52</b>		10 IF UNDER 1 YEAR Months <b>2</b> Days <b>23</b> Hours <b></b> Min <b></b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
11 BIRTHPLACE (State or foreign country) <b>Redwood, Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>William Crook</b>		14 MOTHER'S MAIDEN NAME <b>Lillie (Unknown)</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>Unknown</b>	
17 INFORMANT <b>Husband</b>		Address <b>Maynard Spangler Same as Item 2.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Pulmonary Emphysema</b> DUE TO (c) <b>Fibrocalcification Pulmonary Diffuse</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2</b> years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b>		22. DATE SIGNED <b>9/25/66</b>	
EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Bethesda, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>9-27-66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Calloway Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Calloway, Virginia</b>
24 FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a REC'D BY REGISTRAR <b>SEP 27 1966</b>	25b REGISTRAR'S SIGNATURE <b>J. Jones Judge</b>

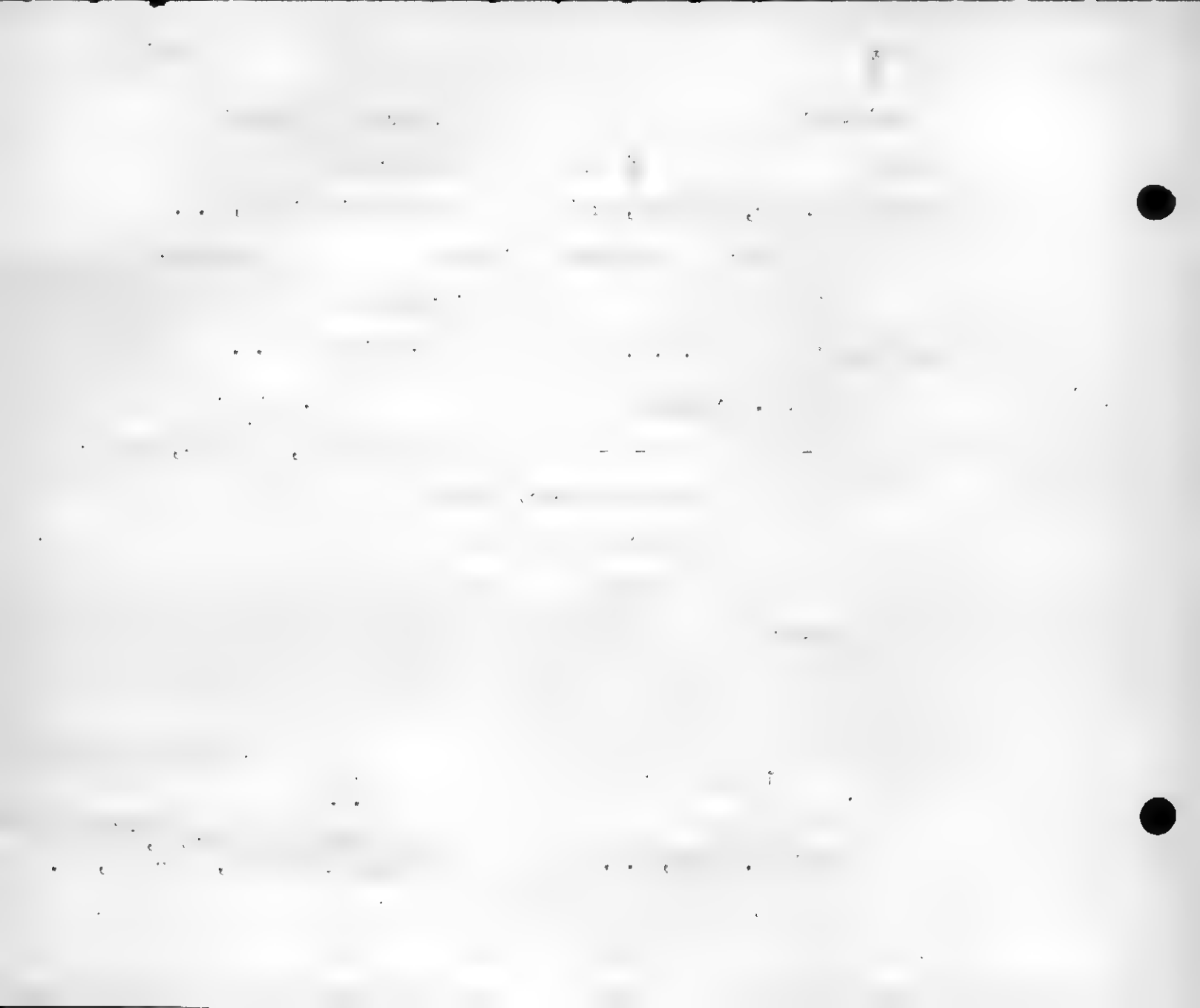


CERTIFICATE OF DEATH

13047

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>28 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>5330 Sherrier Place, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edward Dalridge Spedden</b>		4. DATE OF DEATH Month Day Year <b>September 1 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 January 1898</b>
9. AGE (In years last birthday) <b>68 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Administrative</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C.&amp;P. Telephone Co. Washington, D.C.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William D. Spedden</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Beavers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1914-1918</b>		16. SOCIAL SECURITY NO. <b>577-01-0462</b>	
17. INFORMANT <b>The Medical Records</b>		Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Systemic Amyloidosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Polycythemia</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>7 July</b> , 19 <b>66</b> , to <b>1 September 66</b> , that <del>we</del> (we) last saw the deceased alive on <b>1 September 19 66</b> , and that death occurred at <b>3:10 M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L R Chase M.D.</b>		22b. DATE SIGNED <b>1 September 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lewis R. Chase, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 6, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem. Arlington, Virginia.</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>H. Roy. DeVol</b>		24b. ADDRESS D.C. <b>2222 Wis. Ave. N.W. Washg.</b>	
25a. REC'D BY REGISTRAR <b>SEP 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13048

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Mont.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN ID <b>23 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington, Md.</b>			
f. STREET ADDRESS <b>3121 Jennings Rd.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARYDALE</b> Middle <b>Speitler</b> Last				4. DATE OF DEATH Month <b>Sept.</b> Day <b>22</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-21-33</b>	
9. AGE (In years last birthday) <b>33 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Private Secretary</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Publishing Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>							
13. FATHER'S NAME <b>Robert Morris</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Corkhill</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>577-42-4505</b>		17. INFORMANT <b>Dolan R. Speitler, Same as #2 above.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis (clinical)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Sub-Phrenic Abscess &amp;</b> DUE TO (c) <b>Wound infections &amp; Regional Enteritis</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-30</b> , 19 <b>66</b> , to <b>DEATH</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9-21</b> , 19 <b>66</b> , and that death occurred at <b>12:22 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Ira Miller</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/22/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Ira Miller</b>				22d. ADDRESS <b>8218 Wisconsin Ave. Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Sept 24, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forthinola Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Bladensburg, Maryland</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Inc. Silver Spring, Md.</b>				25a. REC'D BY REGISTRAR <b>SEP 23 1966</b>			
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

14-N

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13049

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CORNER NOTIFIED AND APPROVED

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>472</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1400 Roxanna Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Solomon mnm Spigel</b>		4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/1881</b>
9. AGE (In years birth day) <b>85</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Radom, Poland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Benjamin Spigel</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1966</b> , to <b>Sept 23, 1966</b> , that (II) (we) last saw the deceased alive on <b>Sept 1, 1966</b> , and that death occurred at <b>8:15 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>9/24/66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/25/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Adas Israel Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons St. NW, Wash. DC</b>		25a. REC'D BY REGISTRAR <b>SEP - 1966</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 20 Film 382  
10-21-66 ans.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3056

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13050

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hosp.</u>				e. STREET ADDRESS <u>7311 Piney Br Rd</u>			
3 NAME OF DECEASED (Type or print) <u>Gecil Glenn Stamm</u>				4 DATE OF DEATH <u>Sept 13 1966</u>			
5 SEX <u>M</u>		6 CO. OR RACE <u>Cauc.</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH <u>June 9 1911</u>	
9 AGE (In years, lost birthday) <u>55</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of work life even retired) <u>Cab Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cab</u>		11 BIRTHPLACE (State or foreign country) <u>Sunbury, Penna.</u>	
12 CT. ZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>William Stamm</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Walshaw</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. co.) <u>Yes WWII</u>			
16 SOCIAL SECURITY NO <u>57722572</u>				17. INFORMANT <u>Police Dept., Tak. Park, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure due to</u> <u>condition</u> DUE TO (b) <u>Barbiturate intoxication, self-administered</u> DUE TO (c) <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>				19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased took overdose of barbiturate (apparently accidental)</u>			
20c. TIME OF INJURY Month, Day Year <u>2:00 PM 9-10 1966</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <u>Home</u>				20f. (City or town) (County) (State) <u>Takoma Park Montgomery Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John R. Stamm</u> M.D.				22. DATE SIGNED <u>Sept. 1966</u>			
EXAMINER'S NAME (Type) <u>John R. Stamm</u>				23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>9/14/66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Com.</u>			
23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>				24 FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>			
25a. REC'D BY REGISTRAR <u>SEP 15 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13057

13051

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9000 Stewart Avenue</b>		d. STREET ADDRESS <b>9000 Stewart Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Albert Stewart</b>		4. DATE OF DEATH <b>Sept. 1, 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1883</b>
9. AGE (In years last birthday) <b>83 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Stewart</b>		14. MOTHER'S MAIDEN NAME <b>Louise Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Emma Stewart</b>		Address <b>same as item #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Prostate</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized Carcinomatosis</b> DUE TO (c) <b>2 years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7-11, 1966</b> to <b>9-1, 1966</b> that (I) (we) last saw the deceased alive on <b>8/31, 1966</b> and that death occurred at <b>2 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Calvin B. LeCompte</b> M.D.		22b. DATE SIGNED <b>9/1/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>CALVIN B. LeCompte</b>		22d. ADDRESS <b>61 R. St. NE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/4/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial</b>	23d. LOCATION (City or town) (County) (State) <b>Sandy Spring, Md.</b>
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>		25a. REC'D BY REGISTRAR <b>SEP 3 1966</b>	
ADDRESS <b>Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

13052

2058

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If possible, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>1 1/2 hrs.</u>		d. STREET ADDRESS <u>8308 Flower Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Cover Strunk</u>		4. DATE OF DEATH Month Day Year <u>Sept. 5 1966</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-91</u>
9. AGE (In years Just birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR IND. STRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. American</u>	
13. FATHER'S NAME <u>Thomas Davis</u>		14. MOTHER'S MAIDEN NAME <u>Russell, Magdaline</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>no None</u>		16. SOCIAL SECURITY NO <u>578-50-2834</u>	
17. INFORMANT <u>Mrs. Virginia Nelson</u> Address <u>8308 Flower ave. Med records - W.S.H. Jk. Pk. Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction - R. ventr.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7:30 PM</u> , 19 <u>66</u> , to <u>5:30 PM</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7:30 PM</u> , 19 <u>66</u> , and that death occurred at <u>4:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Wilson, Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Wilson, Jr.</u>		22d. ADDRESS <u>1801 Eye St., N. W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sep. 7, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>Clark E. Wison Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 9 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

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3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>La Conner</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>La Conner</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>					d. STREET ADDRESS <u>P.O. Box 464</u>				
3. NAME OF DECEASED (Type or print) <u>Michael DeWitt Suit</u>					4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1966</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-11-46</u>		9. AGE (In years last birthday) <u>20</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>Wash.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Ernest A. Suit</u>					14. MOTHER'S MAIDEN NAME <u>Betty Ward</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>					16. SOCIAL SECURITY NO. <u>533 44 9643</u>				
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture inferior vena cava with exsanguination</u> 5224 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>due to automobile accident</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was riding in car on MS 70, lost control - turned over</u>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. TIME OF INJURY Month, Day, Year Hour <u>2</u> a.m. <u>9/8</u> 1966				
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 705</u>				
20e. (City or town) <u>Gaithersburg</u>					20f. (County) <u>Montgomery</u>				
20g. (State) <u>Md.</u>					21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
22. DATE SIGNED <u>9/8/66</u>					23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
24. ACTUAL SIGNATURE <u>John G. Ball</u>					25. EXAMINER'S NAME (Type) <u>John G. Ball</u>				
26. ADDRESS <u>W.W. Chambers Co Inc 1400 Chapin St NW Wash, D.C.</u>					27. REC'D BY REGISTRAR DATE <u>SEP 13 1966</u>				
28. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					29. LOCATION (City, town or county) (State) <u>Mt. Vernon, Wash.</u>				
30. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					31. DATE THEREOF <u>9/12/66</u>				
32. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon</u>					33. LOCATION (City, town or county) (State) <u>Mt. Vernon, Wash.</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																				
<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN ID <u>740 - 17 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NRSG HOME 2101 FAIRLAND RD.</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEORGE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u> d. STREET ADDRESS <u>6831 KIRBY DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
<b>3. NAME OF DECEASED</b> (Type or print) First <u>GRACE</u> Middle <u>HAMILTON</u> Last <u>SULLIVAN</u>			<b>4. DATE OF DEATH</b> Month <u>SEPT</u> Day <u>12</u> Year <u>1966</u>			<b>5. SEX</b> <u>FEMALE</u>			<b>6. COLOR OR RACE</b> <u>WHITE</u>			<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>FEB 28, 1896</u>			<b>9. AGE</b> (in years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>BEAUTICIAN</u>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>WASHINGTON, D.C.</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>								
<b>13. FATHER'S NAME</b> <u>SAMUEL F. FOWLER</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>DAVIS, Alice E</u>														
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						<b>16. SOCIAL SECURITY NO.</b>			<b>17. INFORMANT</b> <u>Edward F. Sullivan</u> Address <u>4315 - Walden Dr Temple Hills Md</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> (b) <u>CORONARY ARTERIOSCLEROSIS</u> (c) <u>generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral ARTERIOSCLEROSIS, Senile psychosis</u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Instant</u> <u>2-YRS</u> <u>Several</u>								
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																				
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>												<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)								
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>												
<b>21. I certify that (I) (this hospital) attended the deceased from Jan 1966 to 9/12, 1966, that (I) (we) last saw the deceased alive on 9/12 1966, and that death occurred at 12:00 PM, from the causes and on the date stated above.</b>																				
<b>22a. SIGNATURE</b> <u>Raymond T. Benack</u> M.D. <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>												<b>22b. DATE SIGNED</b> <u>9/12/66</u>								
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>RAYMOND T. BENACK MD</u>												<b>22d. ADDRESS</b> <u>4115 Colic Dr., Wheaton, Md</u>								
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial Sept 15-66</u>				<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>		<b>23d. LOCATION (city, town or county) (State)</b> <u>Suitland Maryland</u>												
<b>24. FUNERAL DIRECTOR</b> <u>Simmons Bros - 1466 - Good Hope Rd SE</u>												<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <u>SEP 15 1966</u> <u>Charles Judge</u>								



## CERTIFICATE OF DEATH

13055

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12613 Millstream Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>		d. STREET ADDRESS <u>Bowie</u> <u>12613 Millstream Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Charlotte First FAYE Middle Last TALBERT</u>		4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-66</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u> Hours <u>53</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilber D. TALBERT</u>		14. MOTHER'S MAIDEN NAME <u>Audrey S. Branch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>N/A</u>	
17. INFORMANT <u>Wilbur D. Talbert</u>		Address <u>12613 Millstream Dr., Bowie, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9545</u> DUE TO <u>Apnoea</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>? Cong heart disease</u> DUE TO (c) <u>?</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from <u>9/27</u> , 19 <u>66</u> to <u>9/28</u> , 19 <u>66</u> , that (i) (we) last saw the deceased alive on <u>9/28</u> , 19 <u>66</u> , and that death occurred at <u>2:50</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>MI MOVES</u>		22b. DATE SIGNED <u>9-28-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MI MOVES</u>		22d. ADDRESS <u>110 Spring St SS Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Sept. 30, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Harold Wade Lane, Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 1 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Harold Wade Lane, Inc.</u>		25c. REGISTRAR'S SIGNATURE <u>Harold Wade Lane, Inc.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Clearance with Medical Examiner (Dr. Reed)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13056											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 yrs. 7 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Congressional Manor Sanitarium</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westgate</u> d. STREET ADDRESS <u>5110 ALLAN ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLIFFORD ESTELLE TALBOT</u>						4. DATE OF DEATH Month Day Year <u>9 30 1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>83</u> <u>11-26-83</u>		9. AGE (In years last birthday) <u>82 2 1/2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Emory F. Talbot</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Isabelle Campbell</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-68-6273</u>		17. INFORMANT Address <u>Wash. D.C.</u> <u>Mr. B.E. Lanham 5109 Washington Dr.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 77.1X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arterio Sclerosis</u> DUE TO (c) <u>Hypertensive Cerebrovascular Disease</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u> <u>40 yrs.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (1) (this hospital) attended the deceased from <u>March</u> , 19 <u>65</u> , to <u>9-30</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>9/28</u> , 19 <u>66</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Louis Gillespie, Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>LOUIS GILLESPIE, JR.</u>						22b. DATE SIGNED <u>9-30-66</u> 22d. ADDRESS <u>1714 N ST. N.W., WASH. D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>RURAL</u>		23b. DATE THEREOF <u>10-3-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>		23d. LOCATION (City, town or county) (State) <u>SUITLAND, MD.</u>					
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS - 5130 15th AVE., N.W. WASH., D.C. 20016</u>						25a. REC'D BY REGISTRAR <u>OCT 5 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit and if any event within 72 hours after death Health or its designated agent, prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #7 Film #3330 2/15/66 ps									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						13057			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <input checked="" type="checkbox"/>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN 1b <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital of Silver Spring</b>					d. STREET ADDRESS <b>3045 Vista Street, N.E.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William THOMAS</b>					4. DATE OF DEATH Month Day Year <b>September 8 19 66</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-22-06</b>		9. AGE (In years last birthday) <b>60</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Burns, second &amp; third degree, 90% of body area</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____								INTERVAL BETWEEN ONSET AND DEATH <b>25 hrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Painter. Gasoline vapors ignited by hot water heater and flash fire burned him.</b>						
20c. TIME OF INJURY, Month, Day, Year Hour a.m. <b>10:00 a.m.</b> <b>XXXX-7-66</b> 19			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Silver Spring Mont. Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								22. DATE SIGNED <b>9-8-66</b>	
ACTUAL SIGNATURE  M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22. DATE SIGNED	
EXAMINER'S NAME (Type) <b>John S. Rogers, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					9-8-66	
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					Address (Street, city, town, or county)	
23a. BURIAL (CREMATION REMOVAL) (Specify) <b>9-12-66</b>			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Penly</b>		23d. LOCATION (City or town) (County) (State) <b>La Plata Md.</b>		
24. FUNERAL DIRECTOR <b>John Conno Jackson</b>			ADDRESS <b>4804 1/2 Ave N.W.</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1966</b>		25b. REGISTRAR'S SIGNATURE 		



## CERTIFICATE OF DEATH

13058

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chevy Chase Nursing + Convalescent Center</u>		d. STREET ADDRESS <u>1810 Irving St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marietta S. Tucker</u>		4. DATE OF DEATH Month Day Year <u>September 26 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2, 1904</u>
9. AGE (In years lost birthday) <u>62 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>62 yrs</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work on life, even if retired) <u>Research Assistant-Bureau of Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Statistics-Labor Dept.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Street Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis F. Scarborough</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Bailey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Henry A. Tucker, Jr.</u>		Address <u>Washington, D.C. 1810 Irving St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>65</u> , to <u>Sept 26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 22</u> , 19 <u>66</u> , and that death occurred at <u>10</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Harry Friedenberg</u>		22b. DATE SIGNED <u>9/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>HARRY FRIEDENBERG MD</u>		22d. ADDRESS <u>1726 Georgia Ave. Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>10/1/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Georgetown, Del.</u>
24. FUNERAL DIRECTOR <u>The S. N. Nines Co.</u>		25a. REC'D BY REGISTRAR <u>2901 14th St. N.W. Washington D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 28 1966</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

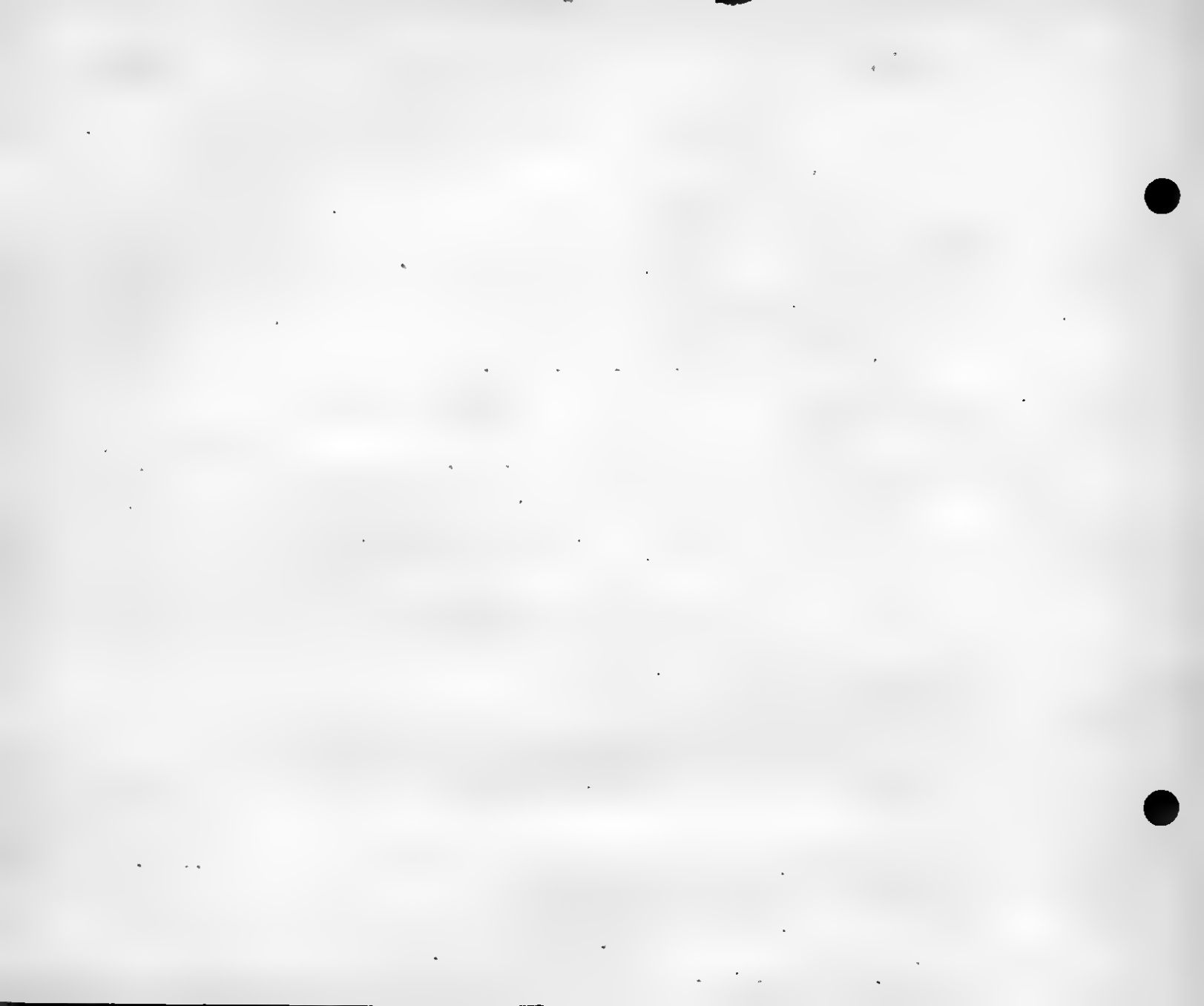
## CERTIFICATE OF DEATH

13059

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hosp.</u>		d. STREET ADDRESS <u>2016 Luzerne ave.</u>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>Stanley</u> Middle <u>XXXXXXXXXXXX</u> Last <u>Jurowski</u>		4. DATE OF DEATH <u>Sept. 21</u> 19 <u>66</u> Month <u>Sept</u> Day <u>21</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-4-1900</u>
9 AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng. Plant operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Was. Sub. San. Comm.</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Poland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Stanley Jurowski</u>	
14. MOTHER'S MAIDEN NAME <u>Alexandria Milewski</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u>	
16 SOCIAL SECURITY NO <u>215-38-3118</u>		17. INFORMANT <u>Pearl R. Jurowski</u> Address <u>2016 Luzerne Ave. Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute myocardial inf.</u> 4225 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. myocardial inf.</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</u> <u>Unk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> , 19 <u>65</u> , to <u>9-21</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>9-16</u> , 19 <u>66</u> , and that death occurred at <u>9</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Rogers</u> M.D.		22b. DATE SIGNED <u>9-21-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John S. Rogers</u>		22d. ADDRESS <u>1919 Seminary Rd., S. S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sep. 23, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>John B. Thomas</u> 25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>	
ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		DATE <u>SEP 26 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

13060

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>13808 Old Columbia Road</b>		d. STREET ADDRESS <b>3001 Cyrandal Valley Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Catherine</b> Last <b>Underwood</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>5</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1885</b>
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (In years last birthday) <b>81</b> yrs
11. BIRTHPLACE (County & State, or foreign country) <b>Loudoun Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John T. Milstead</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Thomas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Raymond T. Underwood, Oakton, Virginia</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> 4200 DUE TO <b>Congestive heart failure</b> (b) <b>arteriosclerotic heart disease</b> DUE TO <b>apoptosis</b> (c) <b>known</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <b>Old C.V. Aest hemiplegia (3) Marked emaciation</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVA. BETWEEN ONSET AND DEATH <b>10-12 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>11-4-65</b> to <b>9-5</b> , 19 <b>66</b> that (1) (we) last saw the deceased alive on <b>9-4</b> , 19 <b>66</b> , and that death occurred at <b>1200</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>John R. Spencer</b>		22b. DATE SIGNED <b>9-5-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John R. Spencer</b>		22d. ADDRESS <b>BURTONSVILLE, MONTGOMERY CO., MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept. 7, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chestnut Grove</b>	23d. LOCATION (City or Town) (County) (State) <b>Herndon, Fairfax Co., Va.</b>
24. FUNERAL DIRECTOR <b>Charles Judge</b>		25a. RECEIVED BY REGISTRAR <b>SEP. 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13075

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner: Dr. Belden Keap called concerning this case and he authorized the design certificate.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 weeks 5 days</u> <u>Wheaton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>11503 Amherst Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Zimmerman</u> Last <u>Zimmerman</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1966</u>			
SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25, 1881</u>	
9. AGE (in years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Long Island, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Franklin Smith</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes give year or dates of service) <u>213-54-6636</u>		17. INFORMANT <u>Gertrude Z. Salmon</u>		Address <u>11503 Amherst Ave. Wheaton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebro-sclerosis</u> DUE TO (c) <u>Auricular Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>23 days</u> <u>Undetermined</u> <u>Undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture right hip joint</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Yes</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Amic from Cerebro-sclerosis fall in home May 27, 1966</u>					
20c. TIME OF INJURY Month, Day, Year <u>8:30</u> Hour <u>a.m.</u> <u>May 27, 1966</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring</u> <u>Montgomery</u> <u>Md</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10</u> , 19 <u>66</u> , to <u>Sept 22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 21</u> , 19 <u>66</u> , and that death occurred at <u>3:00</u> p.m., from the causes and on the date stated above.							
22a. SIGNATURE <u>George L. Ball</u>				22b. DATE SIGNED <u>Sept 22, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 26, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount St. Mary's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Flushing, Long Island N. Y.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>for Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH 13061

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>Rockville</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holy Cross Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>1104 Parrish Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILBUR L. Van Pelt</b>		4. DATE OF DEATH <b>9 - 16 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/5/14</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George F. Van Pelt</b>		14. MOTHER'S MAIDEN NAME <b>Louise Mossefin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>477-30-7331</b>	
17. INFORMANT <b>Wilbur F. VanPelt - Item # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Carcinoma</b> DUE TO (b) <b>adenocarcinoma of colon</b> DUE TO (c) <b>Pneumonia</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2/1, 1958 to 9/16, 1966</b> , that (I) (we) last saw the deceased alive on <b>9/16/1966</b> , and that death occurred at <b>4:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stephen N. Jones</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22b. DATE SIGNED <b>9/17/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>			
22d. ADDRESS <b>Rockville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Shipment 9/20/66</b>			
23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY <b>Warren Cemetery</b>			
23d. LOCATION (City, town or county) (State) <b>Warren, Minnesota</b>			
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike</b>			
25a. REC'D BY REGISTRAR <b>SEP 20 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



## CERTIFICATE OF DEATH

13062

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>	
c. LENGTH OF STAY in ib <b>99 days</b>		d. STREET ADDRESS <b>211 Prince Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital, Bethesda, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eleanore Maria VAN SWEARINGEN</b>		4. DATE OF DEATH Month <b>September</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 May 1904</b>
9. AGE (In years last birthday) <b>62 yrs</b>		10. UNDER 1 YEAR Months <b>62</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Artist/Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Philippine Islands</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Philippine Islands</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Weston Percival Chamberlain</b>		14. MOTHER'S MAIDEN NAME <b>Eleanore Busch</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Earl Kendall VAN SWEARINGEN</b>		18. ADDRESS <b>211 Prince St., Alexandria, Virginia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesonephroma with massive metastases</b> 1150 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>21 June</b> , 19 <b>66</b> , to <b>28 September</b> , 19 <b>66</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>28 September</b> , 19 <b>66</b> , and that death occurred at <b>12:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Donald W. Cowherd</i>		22b. DATE SIGNED <b>30 Sept. 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Donald W. Cowherd, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/3/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery, Arlington, Virginia</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <i>Demaine Funeral Home</i> <b>Demaine Funeral Home, Alexandria, Virginia</b>		25a. REC'D BY REGISTRAR <b>OCT 3 1966</b>	25b. REGISTRAR'S SIGNATURE <i>John W. Cowherd</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or interment, and in any event, within 72 hours after death.

VP A15 (4)  
20 M 1/66

BP

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

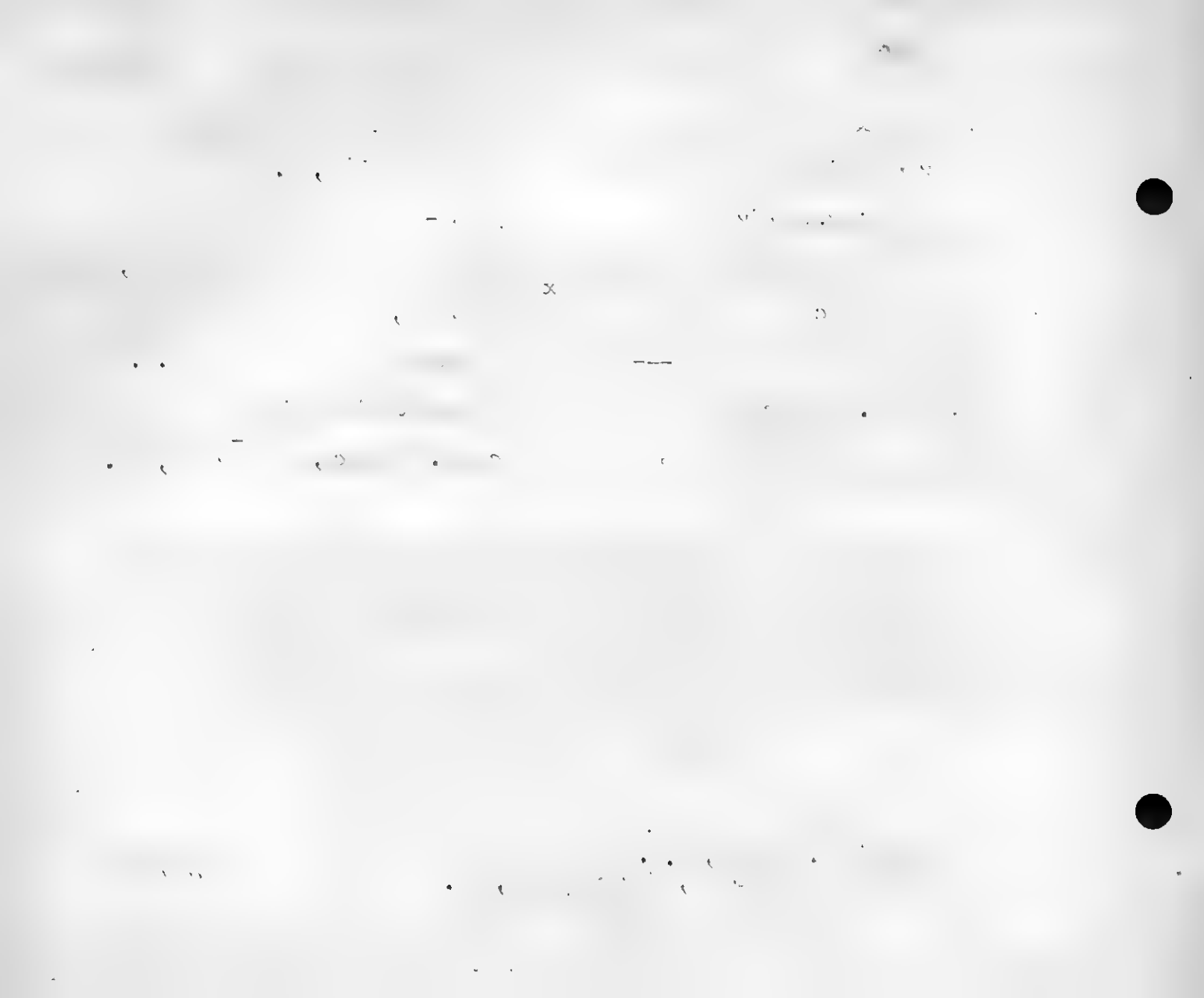
CERTIFICATE OF DEATH

13063

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>@ 6 MOS.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		d. STREET ADDRESS <b>304 MONROE ST. Apt. 3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sylvan Manor Health Care Center</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LORETTA R. VON CULIN</b>		4. DATE OF DEATH Month <b>SEP</b> Day <b>9</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 24, 1896</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK - GSA</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ELON F. VON CULIN</b>		14. MOTHER'S MAIDEN NAME <b>MARY LORETTA LLOYD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>577-16-7623</b>	
17. INFORMANT <b>DECEDENT</b>		Address	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Transition</b> DUE TO <b>Coronary Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Coronary Artery Disease</b> (b) <b>Coronary Artery Disease</b> (c) <b>Coronary Artery Disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 22, 1966</b> to <b>Sep 9, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 8, 1966</b> , and that death occurred at <b>2:30 PM</b> from causes and on the date stated above			
22a. SIGNATURE <b>Robert T. Thibadeau</b> M.D.		22b. DATE SIGNED <b>SEP 9-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT T. THIBADEAU</b>		22d. ADDRESS <b>11000 OLD GEORGETOWN RD, ROCKVILLE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/13/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, MD.</b>	
24. FUNERAL DIRECTOR <b>JAMES T. RYAN, INC. 317 22nd Ave SE WASH, 20003, D.C.</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



VR A:5ME (5)  
5M 1/65



## CERTIFICATE OF DEATH

13065

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. LENGTH OF STAY IN 16 <u>16 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC VALLEY NURSING HOME</u> <u>POTOMAC VALLEY ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDITH</u> First Middle Last <u>WEBB</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>23</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16, 1883</u> 83 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
10. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia, Pa.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
12. FATHER'S NAME <u>Charles A. Parent</u>		13. MOTHER'S MAIDEN NAME <u>Kate Redford</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		15. SOCIAL SECURITY NO. <u>578-62-0297</u>	
16. INFORMANT <u>Grace Bulloch, Dtr., Same as #2</u>		Address _____	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>ruptured descending aorta</u> (b) <u>Dehydration of Colon</u> DUE TO <u>Dehydration of Colon</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis with Chronic Brain Synd</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 17, 1966</u> , to <u>Sept 23, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept 22, 1966</u> , and that death occurred on <u>Sept 23, 1966</u> from causes and on the date stated above			
22a. SIGNATURE <u>E. Herbert Bowersfeld</u> M.D.		22b. DATE SIGNED <u>9/23/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. Herbert Bowersfeld</u>		22d. ADDRESS <u>1912 R St. NW. Wash. DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/26/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Joe. Bowersfeld</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 27 1966</u>	
ADDRESS <u>Washington, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>1</div> <div> <div>1</div> <div>2</div> </div> <div> <div>3</div> <div>4</div> </div> <div> <div>5</div> <div>6</div> </div> <div> <div>7</div> <div>8</div> </div> <div> <div>9</div> <div>10</div> </div> <div> <div>11</div> <div>12</div> </div> <div> <div>13</div> <div>14</div> </div> <div> <div>15</div> <div>16</div> </div> <div> <div>17</div> <div>18</div> </div> <div> <div>19</div> <div>20</div> </div> <div> <div>21</div> <div>22</div> </div> <div> <div>23</div> <div>24</div> </div> <div> <div>25</div> <div>26</div> </div> <div> <div>27</div> <div>28</div> </div> <div> <div>29</div> <div>30</div> </div> <div> <div>31</div> <div>32</div> </div> <div> <div>33</div> <div>34</div> </div> <div> <div>35</div> <div>36</div> </div> <div> <div>37</div> <div>38</div> </div> <div> <div>39</div> <div>40</div> </div> <div> <div>41</div> <div>42</div> </div> <div> <div>43</div> <div>44</div> </div> <div> <div>45</div> <div>46</div> </div> <div> <div>47</div> <div>48</div> </div> <div> <div>49</div> <div>50</div> </div> <div> <div>51</div> <div>52</div> </div> <div> <div>53</div> <div>54</div> </div> <div> <div>55</div> <div>56</div> </div> <div> <div>57</div> <div>58</div> </div> <div> <div>59</div> <div>60</div> </div> <div> <div>61</div> <div>62</div> </div> <div> <div>63</div> <div>64</div> </div> <div> <div>65</div> <div>66</div> </div> <div> <div>67</div> <div>68</div> </div> <div> <div>69</div> <div>70</div> </div> <div> <div>71</div> <div>72</div> </div> <div> <div>73</div> <div>74</div> </div> <div> <div>75</div> <div>76</div> </div> <div> <div>77</div> <div>78</div> </div> <div> <div>79</div> <div>80</div> </div> <div> <div>81</div> <div>82</div> </div> <div> <div>83</div> <div>84</div> </div> <div> <div>85</div> <div>86</div> </div> <div> <div>87</div> <div>88</div> </div> <div> <div>89</div> <div>90</div> </div> <div> <div>91</div> <div>92</div> </div> <div> <div>93</div> <div>94</div> </div> <div> <div>95</div> <div>96</div> </div> <div> <div>97</div> <div>98</div> </div> <div> <div>99</div> <div>100</div> </div>											
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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Rowan</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN ID <u>2 months</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>					d. STREET ADDRESS <u>318 Corriher Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Junius</u> Middle <u>Zed</u> Last <u>Whirlow</u>					4. DATE OF DEATH Month <u>September</u> Day <u>8</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 19, 1891</u>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Electrician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Coca Cola Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Whirlow</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Michael</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>240-09-6034A</u>		17. INFORMANT <u>Mrs. Richard A. Faust</u> Address <u>515 Dennis Ave. Silver Spring, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF ESOPHAGUS</u> 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>7/7</u> , 19 <u>66</u> to <u>SEPT. 8</u> , 19 <u>66</u> , that (II) (we) last saw the deceased alive on <u>SEPT. 8</u> , 19 <u>66</u> , and that death occurred at <u>5:45</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>James A. Roberts</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>SEPT. 8, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>James A. Roberts</u>					22d. ADDRESS <u>8907 Georgia Ave., S. S., Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Sep. 10, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>City Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, N. Carolina</u>		
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u>					ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>		
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									



## CERTIFICATE OF DEATH

13068

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock-Spring-Croftsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock-Spring-Croftsville (Rockville)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13117 Dunbarton Drive</u>		d. STREET ADDRESS <u>13117 Dunbarton Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Ernest</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-22</u>
9. AGE (In years last birthday) <u>44</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Geodesist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Monrovia, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry O. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Lenore Hogue</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>482-16-1878</u>	
17. INFORMANT <u>Wife</u>		Address <u>Gwen H. Williams as above #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 16-1 DUE TO (b) <u>Bronchogenic Carcinoma</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>few days</u> <u>8 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>9/12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/9</u> , 19 <u>66</u> , and that death occurred at <u>2:30 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>G. Leonard Gold</u>		22b. DATE SIGNED <u>9/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Leonard Gold</u>		22d. ADDRESS <u>8641 Colesville Rd., S. S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sep. 17, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blencoe Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Blencoe, Iowa</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>SEP 15 1966</u>	
ADDRESS <u>4834 Georgia Ave. Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13069

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>48 hrs</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. TARIUM Hospital</u>		d. STREET ADDRESS <u>7812 Boston Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>MAE</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-08</u> 9. AGE (in years last birthday) <u>57</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>D.C. - WASH.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>PATRICK GLEASON</u>		14. MOTHER'S MAIDEN NAME <u>NETTIE WILBURN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>577-03-1318</u>	17. INFORMANT <u>Wm. E. Wilson</u> Address <u>7812 Boston Ave. Silver Spring, Md.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Weeks</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-14</u> , 19 <u>66</u> , to <u>9-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-16</u> , 19 <u>66</u> , and that death occurred at <u>10:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Stuart L. Nelson</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9-16-66</u>
22c. PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>		22d. ADDRESS <u>831 University Blvd., E. S. S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sep. 20, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>	25b. REGISTRAR'S SIGNATURE <u>John E. Gedge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

13070

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN lb <u>18h-45m.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1404 CROSS</u>		e. STREET ADDRESS <u>2821 Hathaway Terrace</u>	
3. NAME OF DECEASED (Type or print) <u>ANDRIANNE</u> First <u>WOODICKA</u> Middle Last		4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>18</u> Min. <u>45</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery - Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard Edward Woodicka</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA JEANNE FASICK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>MOTHER</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Phlebotomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/15</u> , 19 <u>66</u> , to <u>9/16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/15</u> , 19 <u>66</u> , and that death occurred at <u>7:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9/16/66</u>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9-17-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Burial Glen</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring</u>
24. FUNERAL DIRECTOR <u>Thos B. Noland</u>		25a. REC'D BY REGISTRAR <u>4748 - N. Ave. 7th</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Items 1 & 21 Film 302 11-3 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13071

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San &amp; Hospital</u>				2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8827 Brookville Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Hilkey</u> Last <u>Young</u>				4 DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1966</u>			
5 SEX <u>male</u>		6 COLOR OR RACE <u>negro</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>1-2-17</u> 49 yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13 FATHER'S NAME <u>Leslie Columbus Young</u>				14 MOTHER'S MAIDEN NAME <u>Emma Jackson</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO.		17 INFORMANT Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia, cause undetermined</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b DATE THEREOF <u>10/4/66</u>		23c NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
24 FUNERAL DIRECTOR <u>Robert L. Sauerden</u>				ADDRESS <u>Rockville, Md.</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
				25b REGISTRAR'S SIGNATURE		22. DATE SIGNED <u>9-29-1966</u>	

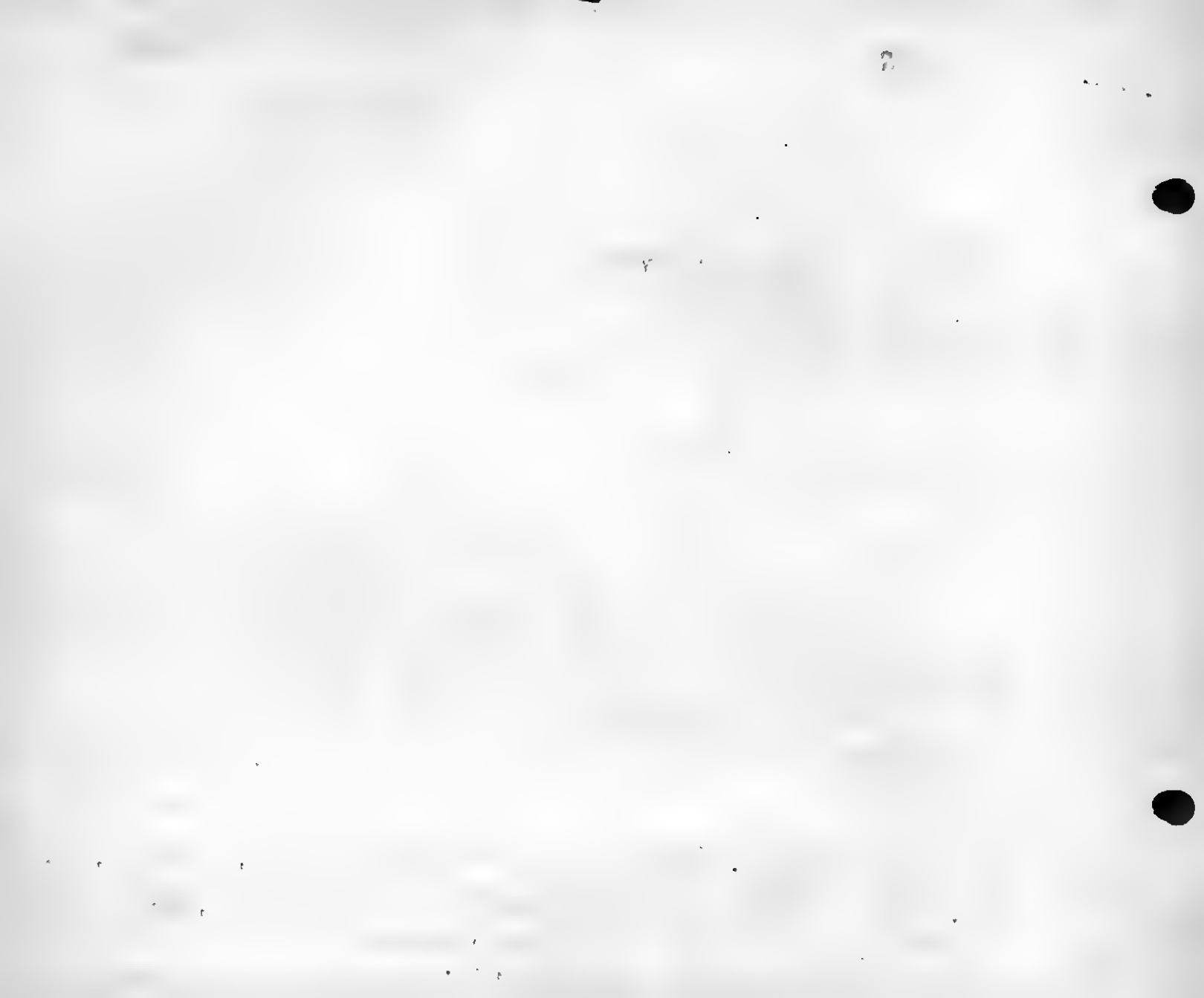


CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>5815 - 1st. Ave.</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>KING HENRY</u>		4. DATE OF DEATH <u>Sept 12 1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automotive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md. Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Young</u>		14. MOTHER'S MAIDEN NAME <u>Young</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>545-01-1615</u>	
17. INFORMANT <u>Mrs. James Morris</u>		Address <u>Home</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> +211 DUE TO (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Coronary Thrombosis</u>			INTERVA. BETWEEN ONSET AND DEATH <u>72 hrs</u> <u>72 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post. Emphysema</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/10/66</u> to <u>9/12/66</u> that (I) (we) last saw the deceased alive on <u>9/12/66</u> , and that death occurred at <u>6:00 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen N. Jones</u> M.D.		22b. DATE SIGNED <u>9/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>		22d. ADDRESS <u>809 Veirs Mill Road, Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>	23b. DATE THEREOF <u>9/16/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillside Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Minneapolis, Minnesota</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25. BY REGISTRAR <u>Rockville, Md.</u>	
25a. DATE <u>SEP 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
c. LENGTH OF STAY IN 1b <i>18 yrs</i>		d. STREET ADDRESS <i>705 Bonifant Street</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>705 Bonifant Street</i>			
3. NAME OF DECEASED (Type or print) First <i>Louise</i> Middle <i>El. F.</i> Last <i>Young</i>		4. DATE OF DEATH Month <i>September</i> Day <i>8</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 8, 1907</i>
9. AGE (In years last birthday) <i>59 yrs.</i>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>May Hardware Company</i>	
11. BIRTHPLACE (State or foreign country) <i>Somerset City, Md.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jasiah W. Pollitt</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Hayman</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-10-8286</i>	
17. INFORMANT <i>Minnie Jones</i>		Address <i>10016 Brunell Avenue Silver Spring, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inoperable cancer of cervix + Cerv. Rupt. Tube</i> DUE TO (b) <i>Strangulation to necks in neck</i> DUE TO (c) <i>Strangulation wound fresh &amp; some int.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Overweight with poor circulation</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell on large person in back yard while removing lawn &amp; section of sidewalk</i>	
20c. TIME OF INJURY Month, Day, Year <i>12-3 p.m. Sept 8, 1966</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Silver Spring</i> (County) <i>Montgomery</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John S. Rogers</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John S. Rogers</i>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <i>1919 Seminary Rd. Silver Spring, Md.</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept 11, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Allen Cemetery</i>		23d. LOCATION (City, town or county) <i>Allen, Maryland</i> (State)	
24. FUNERAL DIRECTOR <i>Clark E. Wison</i>		25a. REC'D BY REGISTRAR <i>SEP 14 1966</i>	
Address <i>8434 Georgia Avenue Silver Spring, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please place in the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MONTGOMERY STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13080 CERTIFICATE OF DEATH 13074									
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>			c. LENGTH OF STAY IN 1b <b>4 yrs. 5 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL HALL SANITARIUM</b>					d. STREET ADDRESS <b>4329 LELAND ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>E.</b> Last <b>ZELLERS</b>					4. DATE OF DEATH Month <b>SEPT.</b> Day <b>10</b> Year <b>19 66</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-4-1883</b>		9. AGE (In years last birthday) yrs. <b>83</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BROOKLYN, NEW YORK</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>SAMUEL F. EDWARDS</b>					14. MOTHER'S MAIDEN NAME <b>PAULINE FREEMAN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>217-52-7601</b>		17. INFORMANT Address <b>4329 Leland St. CHEVY CHASE, MD</b> <b>MRS. BESSIE ALLISON</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized arteriosclerosis</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>No</b> 19 p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(Transit)</b>		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1952</b> , 19 to <b>Sept 6, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 6 19 66</b> , and that death occurred at <b>2 P.M.</b> from causes and on the date stated above.									
22a. SIGNATURE <b>John B. Umhau</b>			22b. DATE SIGNED <b>9/10/66</b>						
22c. PHYSICIAN'S NAME (Type) <b>JOHN B. UMHOU, M.D.</b>			22d. ADDRESS <b>8805 CONN. AVE. CHEVY CHASE MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>9-12-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D. C.</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, BETHESDA, MD.</b>					25a. REC'D BY REGISTRAR DATE <b>SEP 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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RECEIVED BY

ADMINISTRATIVE

GENERAL HEAD OFFICE

DATE

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REMARKS

RECEIVED BY

ADMINISTRATIVE

GENERAL HEAD OFFICE

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REMARKS

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